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Aesculapia Victrix: Fictions About Women Doctors, 1870-1900

by

Carol-Ann Farkas ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Doctor of Philosophy

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Abstract

This dissertation is a study of fictional representations of medical women published in England and America between 1870 and 1900. First, by uncovering these forgotten "doctress" novels, the dissertation performs a recuperative function and serves as an introductory research guide and bibliography. Second, it examines the doctress novels in relation to the major issues involving the non-fictional women doctors of this period. The concerns of the doctress novels are inextricable from the personal and political interests of real-life women as they redefined, or rejected, new forms of social influence and opportunity. As both historical, and literary, documents, these novels advance our understanding of such real authority and status as professional women were able to acquire, and dramatize the degree to which ideological obstacles stood in their way.

The first chapter explores the representation in these novels of the medical woman as a positive role model for readers. Following the strategy used by the medical women's movement, the novels show female physicians as the perfection of womanly ideals, rather than a threat to them. This strategy downplays the details of the woman doctor's knowledge and practice in favour of making her appear "real," but only in benign social and moral situations. Chapter Two argues that the novels deal with the other threat medical women posed to patriarchal society—economic competition with men—by using

the woman doctor's romantic entanglements to teach readers to consider the need for new male attitudes, and new sexual relationships, to go along with the new female professional. Chapter Three concludes the project by considering the ways in which many women doctors, fictional or otherwise, sought to reconcile their new professionalism with the competing demands of tradition, through a commitment to social issues and social control.

These novelists' well-intentioned portrayals of medical women as paragons of both professionalism and womanliness were successful; however, their very success may have hastened the gradual decline of the medical women's movement in the early part of the twentieth century.

For my grandmothers, Lena and Jeanette; for my parents, Ted and Ivy; and for my husband, Christopher.

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Introduction: Resuscitating the Medical Woman

When I explain to others that my dissertation topic is late nineteenth-century novels about women doctors, the response is invariably first interest, and then perplexity: "Oh!" they exclaim. "Oh—but were there any?" And by "any," they mean—were there any such novels? and more to the point, were there any women doctors in the nineteenth century? It seems that a large number of people, like myself at the start of this project, have an incomplete sense of the history of women in medicine, much less of the fictional female protagonist who is not simply a young lady, but a working professional as well. It was my own curiosity and lack of knowledge about this subject that led me to pursue this project in the first place. As the daughter of a medical woman—my mother is a nurse—and, not coincidentally, as a hypochondriac, I have long had an interest in medicine, and medical narratives. Throughout my childhood, I spent many happy hours watching medical dramas and sitcoms with my mother—*Emergency!*, *M*A*S*H*, *Quincy*, *St. Elsewhere*, various soap operas that invariably centre on hospitals—or reading hospital romances about the exploits of irrepressibly curious and noble young nurses, such as *Candystripers*, or the *Cherry Ames* series. I was fascinated by diseases and treatments, and the mysteries of medical practice and etiquette; and I would assail my mother with endless questions about everything from how anaesthesia works, to why nurses are taught never to contradict doctors, or to attempt to diagnose. But one question that never crossed my mind was why all the doctors in these medical stories were men: I had the vague idea that there were such things as women doctors in real life, but the fictional representation of the medical hierarchy—male doctor over female nurse—seemed too complete and natural ever to question.

It was not until my twenties that I actually consulted a doctor who was also female: and I quickly began to think, unconsciously echoing the arguments of pioneering medical woman Dr. Sophia Jex-Blake, that it was in fact very far from natural for male doctors to dominate a profession the primary clientele of which was female (Jex-Blake, *Medical Women*, 7). Consequently, in addition to a nosophilic interest in medicine and health in general, I began to be interested in learning more about the gendered division of power among the members of the medical profession. When it came time to choose a topic for my dissertation, I had already settled on studying nineteenth-century fiction, but I wondered if there were any way to pursue my medical interests at the same time. But where to begin? I thought of studying the figure of the nurse, the woman who selflessly cares for others either professionally or otherwise—but I was impatient with the idea of spending so much time considering characters as conventional in their feminine self-sacrifice and obedience to patriarchally-imposed ideals as Gaskell's Ruth, Dickens' Esther Summerson, or Allen's Hilda Wade. Then, I could do as so many others have done lately and study the fictional female patient—but I did not want to fall into what seemed to be an all-too-common trap of fixating on Victorian women's victimhood. Surely not all nineteenth-century women were victims of patriarchy and medical science? Were there not any women who actually took on the medical authority of the male doctor for themselves, rejecting the roles of handmaiden or patient?

About this time, a popular drama was running on television that featured a heroic female doctor, battling illness and spreading good will in an American frontier town—*Dr. Quinn, Medicine Woman*; and on public television, Eleanor Bramwell was fighting poverty, ignorance, and her own prejudices in the slums of turn-of-the-century London in *Bramwell*. I have always been ready to learn from television: it occurred to me that if CBS or PBS could uncover historical precedents for their fictional medical women, the historical evidence must not be impossibly elusive. I began researching, first, the history of women in medicine, and second, their existence in nineteenth-century fiction.

And there they were.

By the end of the nineteenth century, there were thousands of women doctors in Europe, and—more importantly for my investigation—in Britain and North America too;

and in fiction, there was a small but significant handful of narratives featuring the woman doctor as a central and frequently admirable character. The woman doctor, it turns out, was no anomaly, of either fiction or history. She was also no victim, at least not in an immediate sense—a discovery which immediately piqued my curiosity, and which made a welcome addition to my understanding of Victorian fiction by and about women.

According to Florence Nightingale, in her *Notes on Nursing*, "Every woman is a nurse" (3)—at one time or another, Nightingale believed, every woman is called upon to care for the well-being of others in ways that are as mundane as they are quietly heroic, and, often, unrecognized. But while it may be that every woman is a nurse, not every woman is a doctor. Images of television advertising's "Dr. Mom" aside, western society has long tended to deny or underplay the influence of women in the sickroom. It is one thing for a mother to care for her family, motivated by love and duty; or for a nurse to care for her patients, motivated by altruism and a mediocre hourly wage; and quite another for a woman to take on the doctor's presumed power over both patient, and nurse—in fact over the process of illness itself. In the long history of western medicine, while women have always cared for the sick, it is only in the last 150 years that women have been able to call themselves physicians, and really only in the last two or three decades that the image of the "Doctor"—once stereotyped as white and male—has become more varied. But although most British and North American medical schools in the late twentieth century report that women comprise about fifty per cent of their students (Pringle, 4-5); and although female physicians now account for a significant minority in medical practice (Lorber, 64), the position of the medical woman is still problematic and complete gender equity has yet to be achieved. The areas of medicine which garner the greatest status and financial reward—such as surgery, or clinical research—are still largely male; the lower status areas, and those associated with stereotypically feminine characteristics, such as family medicine and public health, are still drawing large numbers of female physicians (Lorber, 63). The barriers that once kept women out of the white coats altogether are falling, but there is still progress to be made; and the fact that old prejudices still persist is a measure of how deeply ingrained are society's notions about the proper duty of Woman.

Many of the obstacles facing the medical woman today—and indeed any woman who seeks to succeed in areas traditionally reserved for men and associated with economic and social power—can be traced back through centuries of history: the problem of women in medicine is literally older than the profession itself. But for the purposes of this investigation, we need go no further than England and, to a lesser extent, America in the late Victorian period.[1] By the middle of the nineteenth century, the medical profession had begun to be a *profession*. That is, in addition to agreeing on new, consistent standards for education and training, once-competing groups of practitioners had also put aside their own rivalries and differences just enough to band together to exclude competition and maximize status and profit for themselves. This involved cautious support for the professionalization of nurses (a certified and legislated means of defining a subordinate role for women in medicine), the deliberate marginalization of the midwife—and, in the latter half of the century, a circumlocutory resistance to the growing number of women who were determined to become doctors themselves.

But this is not a paper about the history of women in medicine; or rather, it is a paper about this history as it operates with, and within, the literature of a chosen cultural moment. Specifically, this project will investigate the handful of novels published in the last quarter of the nineteenth century which featured the medical woman as physician, and, in so doing, portrayed varying degrees of female medical competence and authority (for plot summaries of these novels, please see Appendix 1). After having uncovered a number of such doctress novels, I would argue that, far from being unremarkable examples of romance, sensation, or New Woman fiction, these works constitute a very remarkable category in their own right. The doctress novels serve as a prime instance of what Mary Poovey might term "uneven development." That is, these novels act as "border cases," wherein authors and readers can explore the "limits of ideological certainty" (12). Even when the portrayal of women doctors in these novels tends in the end to reinforce the dominant stereotypes of female nurturance and passivity, such an outcome is only possible after a conscious confrontation with alternative possibilities for the female protagonists. That such conflicting views of what many Victorians believed to be a unified image of Woman were at issue at all suggests that the concept of a social order divided by gender was not necessarily inevitable, and that questions and unconventional solutions were conceivable, no matter how threatening they may have been to the status quo.

My investigation of these novels as border cases will necessarily be historical as well as literary-critical. The doctress novels are the focus of literary analysis, and the first observation this analysis reveals is that these are very much novels with a purpose. Their authors are using fiction to make definite points about real, non-fictional issues, specifically the rights and opportunities attendant upon an expanded public and professional role for women. The novels are engaged with the process of history, making connections between themselves and history; consequently, if I am to explore the woman doctor as a fictional character, I must account for, and explicate, these connections. In this dissertation then, I shall, first, establish what the connections are by comparing the fictional portrayal of medical women to our current understanding of their historical circumstances. Second, I shall interrogate the ways in which the novels make use of, or deviate from, their historical connections; here, I will be examining the complex, and not necessarily conscious, persuasive aims of the novels. Finally, I shall discuss the consequences of the novels' attempt to contribute to the late-nineteenth-century movement for women's rights, and the degree to which that contribution was, or was not, successful.

To understand the contribution the doctress novels could possibly make, it is first necessary to understand the historical space that they occupied. For the most part these novels were published over only a thirty-year period, fading in from 1870 onwards, and fading out around the turn of the century. Some might dismiss this brief literary appearance as simply the result of the vagaries of the marketplace, that women doctors were a fad that simply had its day—but it is precisely this faddishness that is of interest. There was something about the social and historical conditions of this period that made it momentarily possible for writers and readers to be interested in the figure of the woman doctor, whether as traditional romantic heroine, competent medical authority, or irreproachable exemplar of morality, culture, and national pride. The conditions of possibility (Poovey, 15) that allowed these novels to emerge may have signalled an ideological break in the clouds, a moment where individuals were able to be aware of their existence within ideology. Normally, the workings of ideology are not apparent, and are made to seem natural, or orthodox, in Bourdieu's terms; but in moments of what Poovey terms "unevenness," glimpses of the artificially-maintained nature of orthodoxy are possible, and heterodox responses may result. A shift in the balance of influence may follow; however, this does not guarantee a radical shift in experience for all individuals. The heterodox may institutionalize its own protest, creating a new status quo or orthodoxy; or the existing orthodoxy may simply absorb the challenges from the heterodox, creating the appearance of change, and once more rendering non-apparent the effort to maintain social relations on the same plane.

Applying these principles to the phenomenon of the woman doctor in fiction, then, I would suggest that these novels do represent a wavering of the force of ideology in society at the time, coincident with the increasing challenges of Victorian women to prevailing notions about the role of Woman in terms of political representation, education, work, sexuality, and influence both in and out of the home. Quite simply, the doctress novels provide a medium of expression, a contained, but not quarantined space where the concerns and consequences of the Woman Question took shape in language; and the textual existence of such ideas was in turn able to imply the possibility of their existence beyond the page. But just as the women's movement as a whole was often unable to shake off the weight of ideology, which imposed real limits on the movement's challenge to the orthodox, so too were these novels limited. The character of the woman doctor was not always as progressive as her choice of profession might imply; her development was often constrained by essentialist notions not only about sex, but also, significantly, about race and class as well, so that for every unconventional, radical element to the novels which might indicate opposition to the orthodox, there might be a highly conventional, reactionary element that weakened the full force of any heterodoxic challenge.

The precise effect these texts may have had on the ideological orientation or awareness of individuals in the period is something that may be impossible to determine. Nevertheless, as Poovey explains, "one does not have to have read a set of specific texts to be bound by the conditions by which they were produced and given authority" (17); that is, the prevailing values that affect the production of texts can affect the production of an individual's attitudes, without any direct contact between text and individual. Moreover, when individuals do read texts, they are in turn constituted by them, as the texts limit the positions that the readers may take in relation to the values embedded in what they read. In other words, while it may not be possible to ascertain what direct influence these novels may have had on their readers, it may be possible to make inferences about the historical, ideological climate surrounding reader, text, and writer, and the indirect relationship the texts may have posited between the readers and their society.

The point of making such inferences about the textual representation of female medical professionals is to gauge the degree to which the heterodox was penetrating orthodox social relations; specifically, by examining the conditions of possibility surrounding the content of these novels, one might then gauge the amount of real authority and status (Bourdieu's symbolic capital) professional women were able to acquire for themselves, and to gauge the degree to which ideological obstacles, imposed from without and within, stood in their way. Ultimately, such an investigation may prove useful to feminists today who are concerned about the progress of women in society: not only may it offer insight into the historical origins of current exclusionary practices; it may also serve as an example of the kinds of ideological blind spots that women can impose on their own progress, when they too get caught up in the apparent naturalness of things as they are.

The same social conditions that made the doctress novel possible, and which allowed it to function in society as one forum for the Woman Question, were also at the same time working to alter the novel as a literary form. As a result, the structural characteristics of the doctress novel affect its contents—and thus its readers—by exerting pressure from two directions. On the one hand, these novels have an anaphoric quality, looking and acting very much like the well-established Victorian domestic fiction, insofar as their resolutions hinge on the traditional marriage plot and the affirmation of middle-class values; the novels demonstrate what Elaine Showalter terms a "feminine" (13) sensibility in the combination of earnest protest with deference to readers' and publishers' conventions.[2] On the other hand, the sometimes subtle, but unconventional way in which these novels often treat their professional heroines cataphorically anticipates, or strengthens, the foundation of New Woman fiction and the early stages of what Showalter terms "female fiction" (13), with its fervent belief in the unique powers of women. That these novels resist being classified neatly into one generic category or another is a further suggestion of their function as sites of ideological uncertainty or negotiation; social forces are at work here to distort, dissolve, and reconceptualize the limitations form can impose on content, which affects form again in turn. My aim in this project is not to impose boundaries on this process, but rather simply to try to unravel the ideological knot the doctress novel forms as the nexus for competing social and literary forces in this thirty-year period of history.

As a nexus, the doctress novels operate as much as historical artifacts as literary ones, and so it seems that to confine my study of them to only one discipline would be inadequate and beside the point. Here, I am drawing upon the ideas of critics such as Mary Poovey, Jill Matus, Rita Kranidis, and Elizabeth Langland, who are in turn elaborating upon such related theories as new historicism, cultural materialism, and cultural studies. Without explicitly labelling this project as being governed by one theory or another, I nevertheless do align myself with the views of such critics insofar as I too find

> a satisfactory answer neither in an examination of the historical record nor in a scrutiny of novels conceived as formal wholes or self-referential structures. [Such an approach] suggests, instead, the limitations of any history of the novel that so circumscribes itself, and, further, argues for a theory acknowledging that cultural events cannot be understood apart from politics, history, and economics. Such a theory forces us to engage other ways of thinking about novels, to see narratives as discursive practices bound up in and implicated in other discursive practices through which a culture's meanings are articulated. (Langland, 3)

Moreover, such an approach also helps to justify the study of texts whose value as works of "high" literary art may be in question. Since this approach is concerned with understanding "the interacting texts through which a culture represents itself and the shared and conflicting ideological economies that inform these discursive formations" (Langland, 3), literary merit becomes only one criterion among many in the choice of texts for study. The text becomes interesting for what it *does*, in terms of Poovey's idea of "ideological work" (17), rather than for what it is or is not—categorizations which, as critics like John Guillory or Barbara Herrnstein-Smith point out, are highly contingent upon historically- and culturally-specific notions of status (See Guillory, *Cultural Capital,* and Hernstein-Smith, "Contingencies of Value").

Thus, while I am treating the doctress novels in part as the objects of literary analysis, I would argue that it is extremely difficult, if not impossible, to understand their meaning or their existence without understanding their relationship to history. For example, if the doctress novels contain depths of hidden meaning (and many of them do) it is often as likely a result of historical circumstance as artistic design. And because these stories are concerned with communicating their position clearly (at least on the surface), they do not often challenge the reader with the kind of experiments in symbolism, metaphor, or the rendering of psychological complexity and uncertainty in character and narrator self-consciously theorized and validated by members of the period's *literatti.* While these novels are literary enough to make for a good read—because being readable, I will argue, was essential to their effective functioning—being literature, or high art, does not seem to have been their sole aim.

Or rather, no matter what the authors of these doctress novels may have intended, it does not seem as though their works were received as anything but instances of popular fiction. Reviews are scarce, and most are no more than notices, a finding which suggests that, regardless of the novels' actual sales figures, the literary critical establishment did not regard them as significant.[3] Even if the doctress novels had not outlived their moment of relevance in terms of their content, in the wake of modernism and the rise of twentieth-century literary criticism, they might still have been left behind with so many other works of their day whose respectable sales only highlighted their lack of approved artistic characteristics. As Nicholas Daly observes in regards to another form of popular fiction, the romance of adventure (for example, works by Stevenson, Haggard, Stoker), the association of popularity with a lack of literary or stylistic merit is an artificial one, influenced by a literary-critical perspective that applies the term "modernism" in a privileged and exclusionary way. Daly suggests that both "high" and "popular" works of literature deserve to be placed in the "high" category of modernism; functionally, both forms of literature performed equally important work. If modernism "provided 'ways to absorb, reflect upon, and codify' various facets of modernization . . . the romance . . . did likewise" (24). Paraphrasing Frederic Jameson, Daly states that "modernism provid[es] certain stylistic compensations for the loss of the ability to map the historical totality, while mass culture operates in an essentially narrative register, harmonizing perceived contradictions. The tendency of the former . . . is towards the fetishism of style; that of the latter towards allegories of resolution" (10).

Thus, the fact that the doctress novels, as "novels of incident" (24), do not readily lend themselves to a traditional literary analysis of style, does not mean that they must, or should, remain in obscurity. These popular novels offer "allegories of resolution," wherein their authors attempt to interpret and imaginatively solve the problematic issue of the new medical woman. In so doing, these novels offer an important challenge to preconceptions about the lot of Victorian women. For instance: reading the more canonical Victorian fiction—such as the Brontës, Gaskell, Eliot, Dickens, Gissing, or Hardy—alongside and through modern feminist literary criticism of the period, one might come away with the impression that nineteenth-century women, both in and out of fiction, could best be understood as a code composed of three general terms based usually on class, race, and gender. The terms of this code imply that identity for the Victorian woman was a complex system of loyalties, often resulting as much in complicity as conflict with the prevailing social order. And yet, as much as this view of women allows for complexity, as long as we are complacent about limiting it to these all-encompassing terms, we oversimplify and overlook an even wider range of identities or loyalties that were potentially available to women at the time. Often, our literary criticism, made somewhat narrow by an incomplete view of history, leads us to see our female subjects as crusaders against patriarchy, or capitalism, or imperialism—or as pawns of these ideological forces. But the addition to the code of any extra terms—supplied by a broader consideration of literature within history—complicates everything exponentially. If the Victorian woman becomes defined by class, race, gender, and *profession*, for example, her loyalties become multiplied, and the power and influence she might possess in her social environment increases. She becomes much more intricately situated in relation to surrounding ideology, and much more resistant to current critically popular assumptions about how things must have been. Consider how much work has been done on texts featuring women as patients, as passive subjects to male medical and scientific interests: what happens to our understanding of nineteenth-century relationships between genders, or between doctors and patients, when we discover that women also had the power of medical authority over other women, or, as is the case in more than one doctress novel, over men? The recuperation of such underread novels, and the study of them in light of their relationship to historical forces, adds complicating, but enlightening, terms to the equation.

Before beginning to talk about what these novels mean or do, however, it may first be useful to establish what they are, and what they are not. The late nineteenth century presents readers with a variety of sub-genres of fiction, but no single one of these sub-genres accounts for all of the doctress novels. In fact, the category "doctress novel" encompasses the only categorizations that reliably apply to all the works I have selected for this project: the two things that these narratives have in common is that they revolve around women doctors, and they are novels. I do not mean to use the latter term too flippantly however; the very loose and baggy quality of the term "novel" actually describes the doctress narratives very well, with its implications of accommodating varied combinations of relationships between characters, and varied combinations of generic conventions, while at the same time being more or less verisimilous with respect to the manners and customs of society at the time (Harmon and Holman, 350-353). That is, since most of the novels are concerned with the positive representation of women as medical professionals, the realistic mode predominates, the better to lend credibility and normalcy to the subject matter. Individual instances of the doctress novels definitely employ elements of sensation or romance, but the influence of these antecedent sub-genres is usually secondary to that of the propaganda novel or novel with a purpose, because so many of these novels seem to be sincere and forthright in their desire to advance the cause of medical women.[4] But however earnest these novels may be, I would not say that they are pure examples of any one sub-genre in their own right: the doctress novels, being loose and baggy after all, often contain contradictions and detours that prevent them from being pure examples of anything, including focussed expressions of radical propaganda.

As one searches for somewhere to place these novels on the map of literary history, the obvious location would seem to be the domain of New Woman fiction. The woman doctor was certainly accused of being "New" often enough by her detractors in real life; nevertheless, when compared to contemporaneous examples of the New Woman sub-genre, as well as modern criticism on the subject, the doctress novels emerge as being quite a separate phenomenon. While it is true that the designation of "New Woman," coined by author Sarah Grand in 1884, applied to those women committed to challenging boundaries imposed on them by their society, and especially by the opposite sex, in the domain of literature the label "New Woman" came to have a narrower application. For example, Lloyd Fernando sees New Woman fiction arising out of the reaction in the late nineteenth century to the inherent prudishness of British realism, which, to writers like Meredith, Moore, Gissing, or Hardy, was too much under the control of over-cautious publishers and circulating libraries, and as a result was not realism at all. In this view, New Woman fiction is related to French-influenced naturalism, with its emphasis on the grittier details of "real" life, especially the exploration of sexuality, and the criticism of modern sexual relations, including marriage. But as Elizabeth Langland points out, too often in New Woman fiction, especially in the works of the more noted male writers like Gissing, female sexuality ends up being portrayed negatively, as dangerous and destructive, with the result that in the end it must be "recontained" (240) either by re-educating or chastening the New Woman character.

Gail Cunningham also acknowledges that much New Woman fiction was committed to frankness when it came to discussing sexuality as a component of relationships; but in her analysis she argues that, more generally, this sub-genre was concerned with matters of principle (10). The fictional New Woman was not concerned only with sex, but with larger issues of social change as they affected her on a personal level. Cunningham's reading of New Woman fiction is again rather pessimistic, however: "the New Woman's ideals were far too advanced for her environment . . . Since the system is so pernicious, the odds so heavily weighted, it would be absurdly utopian . . . to portray a New Woman succeeding in her aims" (50). That is, while the New Woman protagonist might reveal possibilities for the personal, psychological emancipation of women, many of the novels nevertheless end on a note of defeat or conciliation.

By contrast, both Rita S. Kranidis and Ann Ardis see New Woman fiction—especially those works by women that are often overlooked, but also more numerous than those written by men—as having more influence than previous critics have given it credit for. Ardis argues that not only did this movement in fiction express more accurately and frankly the complexity of women's sexual and political beliefs, it also helped advance a substantial shift in publishing practices and literary values at the end of the century. On the one hand, New Women fiction, along with other more experimental forms of fiction (for example, the works of the Decadents, or the short fiction featured in *The Yellow Book*) contributed to the demise of the all-controlling publishers and circulating libraries; on the other hand, it inadvertently contributed to the rise of a masculinized modernist aesthetic, by giving male literary "artists" a target to define themselves against. Like other recent New Woman critics, Kranidis and Ardis also concede that New Woman fiction, including works written by women, often ended on a pessimistic note—but not before it had posed serious and disturbing challenges to the social status quo by providing alternatives to the generic and conventional marriage plot for its New Women heroines.

As Ardis points out, these narratives would often cover ground which violated social boundaries, not only through what was considered an indecent discussion of sexual behaviour, but perhaps more threateningly, through a rejection of, or indifference to, male forms of power. The fictional New Woman might find other social arrangements, especially those emphasizing female solidarity among a community of activist women, more rewarding than marriage; and the fiction itself might demonstrate a preference for modes of expression that dwelt outside of the literary as defined by male critics of the novel. In Ardis' analysis, these last affronts account for the gradual decline of New Woman fiction and its exclusion after 1900 from the favour of masculine, modernist critics; to them, she argues, "the novel loses its 'potency,' its generic 'virility,' when it cannot be distinguished from other kinds of writing. Moreover, it cannot be considered part of a 'strong-headed masculine nation's' culture if it focuses inappropriately on sexuality and encourages female readers' hysterical identification with women who violate the code of womanliness" (53).

But it is exactly because so many of the doctress novels make a decided point of *not* violating the code of womanliness that they cannot be considered New Woman fiction. As I will explain throughout this dissertation, most doctress novels constructed their female medical protagonists as exceedingly womanly (though not disturbingly sexual) and as far too competent ever to succumb to hysteria. The medical life is not posited as an alternative to the social order, but rather is shown as a safe vehicle for the successful integration of the New Woman into familiar womanly roles. The medical woman is highly unconventional because of her choice of education and autonomous career; but the doctress novels insist, through their otherwise conventional narrative organization—often including the marriage plot—that her idiosyncrasy can nevertheless be safely accommodated within the forms of social organization. In real life, medical women shared the New Woman's struggles, and often found success or comfort through New Woman strategies, such as rejecting marriage in favour of celibacy, and, instead of creating a family in private, creating an extended series of relationships in public with patients and communities of like-minded activist women. And it was because such changes transgressed the boundaries organizing late-Victorian society that medical women and New Women were perceived as such a threat. New Woman fiction seems generally to have been committed to using the novel as a means of exploring the possibilities of such transgressions further, and sometimes more radically, than could be expected in real life; and just as New Women supporters believed in the importance of challenging the status quo of sex, gender, and class in their narratives, they also challenged the status quo of conventional narrative structure itself, by violating reader expectations, experimenting with non-linear plots and unresolved, pessimistic, and often non-marital endings.

Like New Woman writers, most of the authors of the doctress novels used their textual creations to explore the possibilities—but not for any such openly transgressive goals as either sexual or textual revolution. "Integration" or "accommodation" might be more accurate terms. For the doctress novels' authors, the advocacy of expanded opportunities for women was not about the radical overthrow of the status quo or the blurring of all boundaries and the challenging of all certainties. Just as the goal of many medical women was not to reject the practices and prejudices of the medical profession, but rather to seek acceptance within it, the creators of fictional women doctors were also determined to observe the practices and prejudices of conventional novelistic fiction as far as possible. In terms of both ideological content and narrative structure, the medical woman as a central character in the novel changes everything, challenges much, but destroys little.

The doctress novels, although they focus on a variety of New Woman, are very dissimilar from New Woman fiction; nevertheless, they came to share a similar fate. Both were regarded with disdain (if they were regarded at all) by a masculinist literary establishment which, as Ardis observes, defined literary art as neutral, objective, universally true, formally controlled, atemporal, and apolitical (Ardis 81). Doctress novels are often very sentimental because almost always concerned with romantic love. They attempt to be universally true, but do so in a very politically and temporally contextualized fashion, by taking a stand on the subject of female medical authority and women's rights. And while formal control is a difficult characteristic to define, it is not difficult to observe that the doctress novels—like other popular fiction of the day (Daly, 18)—often seem to emphasize persuasion through the creation of an entertaining plot, rather than through the exercise of formal artistic manipulation. As a result, doctress novels, like New Woman fiction, were quickly identified, and then ignored, as specimens of low, popular culture by the late nineteenth century's increasingly influential male critical establishment; and as Ardis points out, literary criticism, even among feminists, has yet to shake off that early defining influence (5-9, 167-176), accounting for the obscure status of so much popular writing from that period.

Finally, I want to use this space to deal with one issue that is a central motivation to this project, even though it does not always play a central role in the actual investigation. When I began this project I thought that my ignorance of the medical woman in nineteenth-century history and literature was purely my problem—that I had simply been reading the wrong things. But as I have pursued my research, reading a great deal about both women's history, and women's literature from the period, it has often struck me as strange—and frustrating—that these two disciplines seldom overlap. For example, historians rarely go beyond the canon when they use literature as evidence, even though, as John Guillory has persuasively pointed out, canonical works rarely make for unbiased representative samples, especially in the case of the Victorian period, where the canon accounts for only a few of literally thousands of literary texts produced at the time. More significantly, feminist literary critics also tend to stick to narrow samples of both literature and history. Interdisciplinarity is still often more of a goal than a regular practice, as evinced by the fact that while literary critics are increasingly turning to history as a tool for analyzing texts, too many of us are forced to piece together an historical education on the job, never having studied history systematically as a formal part of our literary studies. The result is a huge gap in understanding the inextricable nature of literature's effect on history and vice versa, which unnecessarily muddies our modern critical knowledge of the past, exacerbating that pesky methodological pitfall, situatedness.[5]

A pivotal instance of this discipline gap arose for me out my reading of Nancy Armstrong's study of the English novel, *Desire and Domestic Fiction*. This work makes several important points about the power of fiction to influence its social environment, which I have found useful for this project and for my understanding of the history of the novel; nevertheless, these points are problematized by the very history-literature disjunction which is at issue. The focus of Armstrong's work is the rise of the novel in the eighteenth, through to the mid-nineteenth century. Specifically, Armstrong argues that the organization of the domestic novel around the female individual's interior experiences was central to the emerging self-conception of the British middle class—the emphasis the novel placed on private, family-oriented relationships controlled through mutual surveillance opposed the values of both the aristocracy and the lower class, and served as the necessary defining point for middle-class ideology. But once middle-class values became established, they also ceased to be oppositional, and became institutionalized (or orthodox, in Bourdieu's terms). According to Armstrong, they also ceased to be oriented around the female subject: Armstrong argues that after mid-century, the figure of the supervisory, domestic female gave way to that most successful of middle-class figures, the supervisory professional male. Armstrong specifically identifies the objective, analytical, regulating, and *masculine* stance of the medical or scientific professional as the inevitable realization of dominant ideology in the novel—and society; taken to an extreme, this removed, or alienated, approach to fiction made possible the emergence of modernism.

It seems to be Armstrong's suggestion that this increasing masculinization of writing, and the association of professionalism with masculinity, was responsible for the decline of female influence over social values and the value of feminine modes of perception and authority. This is also in keeping with the arguments advanced by many other critics, from Elaine Showalter (*A Literature of Their Own*) to Kate Flint (*The Woman Reader*) and Gaye Tuchman and Nina Fortin (*Edging Women Out*), in their influential studies of gender and writing in the Victorian period. While they assert that late nineteenth-century writing by women made possible valuable new modes of expression for female experience, they also agree that the decline of female authority in and out of fiction was due to a gradual shift in the dominant ideology towards privileging a critical and artistic approach that was designated as distinctly male. The accumulation of symbolic capital by the male, modernist aesthetic in turn resulted in the loss of symbolic capital by many other forms of fiction, particularly those that the literary critical establishment termed weak and feminine.

I agree to an extent with this understanding of literary production in the late nineteenth century: I will argue later that the adaptable mutability of masculinist, nationalist, and classist orthodoxy imposed many constraints on pro-woman reformers (including women doctors) and writers (including those writing about women doctors), and the degree to which they could conceptualize a revision in social relations. However, I do not find this kind of analysis to be satisfactorily comprehensive for one key reason: it seems to be based on a tacitly accepted assumption that all nineteenth-century women were always uniformly a dominated group (give or take some degree of dominance based on class and race), an assumption that I believe seriously underestimates the efforts of women reformers to improve female influence and activity in the educational and professional worlds.

For example, to return to Armstrong's argument that middle-class values came to manifest themselves in the form of the objective, male, medical or scientific professional: it is Armstrong's contention that because women did not occupy a professional role in society, they could no longer exert authority over its organization. But this completely fails to take into account the existence of the woman doctor. That women *were* able to establish a claim to professional authority—no matter how small or hard-won—suggests that heterodox forces were at work in society; and the fact that women doctors appear in both fiction and non-fiction, in both positive and negative roles, suggests that at least some members of society, male and female, were interested in the challenges the female, professional, authority figure posed to the dominant order. From the 1870s on, medical authority and the scientific gaze as represented in fiction were not the exclusive privilege or manifestation of the male middle-class. On the contrary, female authority and subjectivity, while admittedly increasingly marginalized in and out of fiction, nevertheless complicated any attempts to make impenetrable a homogeneous conceptualization of a specifically male, white, middle-class individual. In fact, it was precisely the emergence of such apparently heterogeneous phenomena as women doctors (or scientists, or scholars) that maintainedVictorian anxiety over the Woman Question for several decades; if women had not posed such a genuine threat to the hegemony of the male middle-class professional, the prevailing orthodoxy of the day would not have had to work so very hard to try to suppress such a threat.

When feminist literary scholars overlook this kind of interplay between texts and history, however accidentally, we do a disservice to our feminist predecessors; worse, we reproduce the very kinds of essentialist, stereotyped thinking that our work is supposed to protest against. I do not mean to suggest that we should pretend that patriarchal forces did not have a definite effect at the time; that would be a revisionist view of history, rather than a recuperative one. But by looking more carefully at the past as it lies between the lines of our present disciplinary boundaries, we may be able to get a more accurate, or at least a more fair, view of the possibilities available for women's lives in the nineteenth century.

Very little critical work has been done on the medical women in fiction, particularly on works by English authors. The two other large projects which attempt to survey a wide range of "doctress" novels are both unpublished dissertations. Kristine L. Swenson's "Treating a Sick Culture: Victorian Fictions of Medical Women" examines the fictional figures of both women doctors and nurses, and explores the ways in which they participated in late-century anxieties about the potentially destabilizing combination of female sexuality and public employment. In her study, which focusses on British fiction from 1850-1900, Swenson argues that the medical woman occupied a conflicted position in Victorian society, and "embodied her culture's anxiety over sexuality, disease, and moral corruption" (8). Female nurses and doctors were "deployed by Victorian writers to combat these social ills" (8); at the same time, however, their role was made suspect by a fraught connection to those other women with public careers, prostitutes. Ann Jurecic's "The 'Genus Medical Woman': Representations of Female Doctors and Nurses in American Fiction from the Civil War into the Twentieth Century" compares the woman doctor in American fiction to the novels' female authors, in order to explore the emergence of a new ethos of women's professionalism. Both authors and doctors, Jurecic argues,

> created diagnostic narratives, evaluating the symptoms of their society, and . . . sought cures in narrative resolutions. By identifying with active and analytic healers rather than passive patients, women writers signaled their desire to be taken seriously as professionals and to have their talents

> and skills respected. Through the association of healing and writing, the woman writer suggests that the professional authority of the medical woman validates her own claim to authorship. (2)

While both of these projects perform valuable work by focussing on specific aspects of the woman doctor's place in late-Victorian cultural discourse, they do not supply a more fundamental literary-historical analysis of the medical woman's genesis in both American and British novels, or her specific contributory role in the evolution of the women's medical movement of the late nineteenth century. The argument which follows provides this fundamental analysis, and is organized by two central aims. First, by simply uncovering and discussing the doctress novels, the dissertation will perform a recuperative function. This attention to an otherwise neglected or overlooked group of works gives them their due share of credit for their unique interaction with late-Victorian culture; furthermore, it reminds readers that there are as yet myriad untapped resources for more thorough study of the period. Thus, I see this project as an introductory research guide and bibliography. Second, my readings of the individual doctress novels will always involve examining them in relation to the major issues surrounding and involving the non-fictional women doctors of the historical moment 1870-1900. My concern throughout will be to make clear the inextricability of the doctress novels from their social context: while it is possible to read them simply as light romantic fiction, there is always present in the background a kind of on-going conversation or exchange referring to the personal and political interests of real-life women as they sought to redefine, or reject, new forms of social influence and opportunities. An analysis of the novels reveals how at least some nineteenth-century observers interpreted one aspect of the woman question, and thus makes a contribution to the historical record by adding a narrative of perceptions to a narrative of facts.

In this project, I will be focussing primarily on the fiction of the medical women's movement in England published between 1870 and 1900, but I will also refer frequently to the doctress novels written in America during the same period. Despite the very differing characters of the two nations and their medical professions at this time, there are nevertheless important similarities both in terms of history, and in terms of the doctress fictions that emerged as a result, that make a discussion of the American novels relevant to the project. First of all, as was the case in England, the mid-nineteenth century saw the emergence of both a cohesive movement for medical professionalization, and the movement for women's rights in the US. Doctors and feminists in England and the US looked to one another for both inspiration and guidance: neither the formation of the American Medical Association in 1847, nor the Seneca Falls Convention of 1848, took place without reference to, and notice from, England.[6] Medical practice in the US had been heavily influenced by populist, democratic philosophy, with the result that public acceptance of alternative medicine, and alternative medical practitioners, including women, was relatively high. But such acceptance was by no means complete, and for the would-be woman doctor in America, the sexual and economic prejudice directed at her by both her society and her profession differed from that combatted by her counterparts in England in degree, but not in kind.

In addition to accounting for what I have chosen to include, I must also account for what I have chosen to exclude. This project does not deal with either the nurse or the midwife only partly out of considerations of space and specificity; mainly, however, I feel strongly that the nurse and midwife cannot be lumped together with the women doctor when discussing this period of history (not to mention our own). By the late nineteenth century, midwifery was struggling to make a professional come-back after being successfully marginalized by mainstream medicine. As a result, midwifery lacked the kind of disciplinary cohesiveness achieved by either doctors (including registered female practitioners) or nurses, and the trained midwife *per se*—as opposed to the untrained neighbourhood midwife still practicing among the very poor—was far more rare than the nurse or doctor with obstetrical training. Nursing, by contrast, was a thriving occupation for women after the mid-century reforms of Florence Nightingale, who had banished the drunken, disorderly lower-class drudge vilified in both fiction and the press, and replaced her with a ministering—and managerial—angel. The Nightingale nurse was a lady, either by birth or by strict, paternalistic training, and was meant to exemplify the best lady-like virtues of modesty, efficiency, compassion, and obedience—not to parents or a husband, but to the supervising Sister and the male doctors. Nightingale and her followers believed that the best hospital was like the home, with all of the traditional, gendered divisions of labour and authority scrupulously maintained; in this arrangement, the power and authority of the female nurse came through the perfection of her womanly duties, not through the adoption of those that belonged properly to men. As Mary Poovey explains,

> . . . the Nightingale nurse represented a compromise between a series of normative oppositions rather than a destabilizing problem. Not a member of a religious sect, she was able to take up her "calling" without arousing religious controversy. Not a "strong-minded woman" like the would-be lady doctor, she was able to engage in health-care work without antagonizing medical men. Neither a mother nor a professional, she was able to nurture her wards and supervise sanitary conditions; she was, in short, able to make the hospital a home and, in so doing, to enhance the reputation of an activity that had been degraded because it was traditionally women's work. (14)

Consequently, nurses met with almost no opposition from the mainstream medical profession; they were greeted as welcome, but relatively non-threatening, additions to medical practice. While women doctors also made a point of emphasizing their womanliness, there was no overlooking the fact that they did represent a very definite challenge to gender relations both in and out of the hospital. In fact, not only were nurses and women doctors not natural allies, many of the latter group were disappointed to find members of the former just as hostile towards them as male doctors. Nurses and women doctors may have had the same sex in common, and so could be said to have shared in being oppressed by patriarchy; nevertheless, in numberless ways, the experiences of these two groups of medical women were radically divergent and cannot be viewed as interchangeable.

Chapter One of this project will begin by examining the socio-economic conditions that permitted, or, as many early feminists argued, necessitated, expanded education and career opportunities for women, especially in the field of medicine. Women's struggle for emancipation was fraught with objections from social commentators on both sides of the Atlantic, made anxious and often rather hostile by the threat educated career-women supposedly posed to society, with its rigorous ordering of class and gender roles. The medical woman in particular was seen as a prime example of the damage change could do to treasured ideals and comfortable social arrangements. As a result, her defenders had to argue strenuously on all fronts—social, moral, economic, scientific—that, rather than threatening all that Woman stood for, the medical woman was in fact the natural expression of the most womanly virtues and skills—and that many other so-called feminine accomplishments made women unnecessarily weak and infantilized. Most of the doctress novels deliberately adopt this same strategy, and use the flexibility of fiction to enhance their supportive portrayal of their female medical protagonists. But while real-life women doctors and their defenders were willing to debate openly the more controversial aspects of women's medical education and practice—for example, working alongside often-vulgar male students, and studying, or dissecting, the anatomy of both sexes—the creators of fictional medical women tend to downplay the more gory physical details of their heroines' careers. Instead, the emphasis is on the fictional woman doctor's professional competence as an enhancement to an already-well-developed sense of womanliness. The novels employ enough medical details only for the medical woman to prove her ability to balance the intellectual and the interpersonal, setting the scene for an often-inevitable romantic relationship with a suitably worthy man.

However, the course of true love rarely runs smoothly in these novels; and I will argue in Chapter Two that it is through the fictional woman doctor's romantic entanglements that the novels attempt to deal with the other threat real-life medical women posed to a largely patriarchal society—economic competition with men. It was one thing for medical women or their fictional counterparts to become educated and self-supporting, and quite another for them to take on the status and profits of an increasingly influential, but historically all-male profession. While many medical men rejected women doctors on the grounds that they were unsexed or unwomanly, many medical women saw in these arguments a subtext of economic jealousy and trades-unionism. In the exchanges which took place in the popular press and the medical journals, medical women and their supporters argued as rationally as they could that there was room in the profession for doctors of both genders to find economic success. In the doctress novels, by contrast, almost no medical women are *shown* to compete directly with men for business. With only one or two exceptions, most novels shift the economic debate onto the romantic and domestic front; resolving economic competition becomes a secondary concern to the didactic purpose of teaching readers to consider the need for new modes of romantic arrangements, and new male attitudes, to go along with the new female professional.

For many women doctors, fictional or otherwise, the struggle to reconcile this new female professionalism with the competing demands of traditional notions about feminine nature found its best resolution in a commitment to social issues. As I describe in Chapter Three, medical women were often motivated, and justified, by a sense of moral and social responsibility. Their commitment to the cause of women's education and work was often only part of a larger interest in reforms—the regulation not only of hygiene, but of behaviour, often for imperialistic or eugenic ends—especially among the lower classes and colonial subjects. And yet, despite the fact that most women doctors were committed to something, it is impossible to generalize about the medical-moral views of medical women as a group, a conclusion which reveals just how complicated the ties of allegiance could be for late nineteenth-century women as ladies, as agents of cultural imperialism, and as scientists. The doctress novels reflect both the reality of medical women's social involvement, and the contradictions occasioned by competing loyalties to gender, class, nation, and profession. Their overt attempt to teach readers of the worth of medical woman's involvement in various public causes carries within it an inadvertent lesson about the demands that ideology could make on the would-be agents of social change. The drive to make the controversial medical woman *non*-controversial exerted pressures within the fiction, with the result that many of the causes which exercised real-life women doctors—especially those concerned with sexual behaviour—are dealt with only obliquely in narrative form. At the same time, however, the novels seem inevitably to promote a view of medical women's social participation that reinforced many essentialist notions about the larger role of Woman in a program of social-economical, racial, and sexual hygiene.

In fact, for the most part, the doctress novels seem to be the result of a careful balancing act pulled off by their authors. On the one hand, the creators of the fictional medical woman were dedicated to representing her as a positive role model for readers; but on the other hand, the strategy that seems to have been tacitly adopted in order to meet this goal involved downplaying the details of real women doctors' knowledge and practice in favour of making the woman doctor appear "real"—but in benign, controlled social and moral situations. As I conclude this project, I will argue that the doctress novels' well-intentioned portrayals of medical women as paragons of both professionalism and womanliness were successful; however, these portrayals also participated in the gradual decline of the medical women's movement in the early part of the twentieth century. The doctress novels followed one of the main strategies employed by real medical women to advance their cause—the use of the essentialist argument that medical practice was only a logical outgrowth of Woman's inherently maternal nature; but by accepting this essentialist view, women also, often unwittingly, accepted the limitations and stereotypes that went with it. By the turn of the century, the "natural" role of mother of the nation's children came to attract more and more women, often with the support of a new generation of medical women who had become complacent about the earlier victories of feminism. For those women who remained committed to maintaining a presence in the medical profession, essentialist thinking, combined with radical shifts in the nature of medical education and practice, led to an increasing gender gap in the division of medical labour, and an increasing decline in both the numbers and the influence of women doctors. In real life and in fiction, the medical woman at the start of the twentieth century came perilously close to extinction.

Chapter One:
Propriety vs. Progress: Womanly Women Doctors in Fact and Fiction

In order to understand the conditions of possibility surrounding the production of the doctress novels, it is necessary to trace their location in the larger stream of nineteenth-century history. The fictional woman doctor and her real-life models were simultaneously contributing causes and effects of the Woman Question. Female doctors seemed to embody a constellation of achievements that could potentially be available to all women: education, independence, professionalism, morality, and service. To many, medical women were both the result of the past efforts of the women's movement, and the promise of the future: but whether this was a promise of progress or disaster was the question yet to be answered.

The doctress novels, I will argue, formed part of the ongoing debate in late-Victorian society as it sought to answer the Woman Question through the most wide-ranging medium of communication of the day: the popular press. The novels worked alongside—responding to, inspired by—the discourse of feminists and their opponents as they struggled to keep up with ever-fluid and evolving ideas about womanhood and femininity. Thus, as I begin my discussion of the doctress novels, and the ideological work they were doing on ideas about womanhood and "womanliness," I want first to create an overview of the discourse environment in which they found themselves. This involves recognizing the historical antecedents for later nineteenth-century feminism and the movement for women's higher education and professionalization, since these developments form one of the essential problems underlying the Woman Question in general, and the anxiety about the role of the woman-as-doctor in particular. The chapter will then move to a discussion of the strategies employed by women's rights supporters to counter anti-feminist objections to changed definitions of the idealized notions of "Woman" and "womanliness." Here, the woman doctor took on the greatest prominence both as a target for criticism, and as the best proof of the criticism's invalid nature. As feminists sought to shift the terms of the debate from the reactionary to the reasonable, the example of women doctors, or logical arguments from actual medical women, played a key defensive role. And, as this chapter asserts in its conclusion, it was as a deliberate attempt to further these arguments in a fictional setting that motivated the portrayal of medical women in the doctress novels.

I. Taking a History: Signs and Symptoms of Nineteenth-Century Feminism

The right and ability of women to practise medicine was only one of the more prominent issues Victorians placed under the larger heading of the Woman Question. "What shall they do?" and "why shall they do it?"—Elizabeth Stuart Phelps was only one among many to pose such questions, as nineteenth-century women in both Britain and North America worked to revise their position in society. But the struggle for female emancipation—for greater access to work, education, and political representation—was not a sudden, new development. Rather, the changing role of Woman was very much a part of the same gradual, cumulative movement of socio-economic history in which shifts in cultural dominance influenced, and were influenced by, shifts in demographics, international politics and local markets, technological and industrial advances, and religious and philosophical opinions.

But while it is nearly impossible to define the exact moment when the Victorian Women's movement "started," it is possible to make some claims as to those historical antecedents which had had the most recent effect on the movement's evolution. As Deirdre English and Barbara Ehrenreich point out in *For Her Own Good: 150 Years of the Experts' Advice to Women*, the Industrial Revolution played a key role in this evolutionary process. Western—especially British and American—culture was transformed by the triumph of the capitalist market system, particularly by its characteristic division of labour. Work which had once been done in the home, and shared or supported by all members of the household, was now removed to its own place, a public, non-domestic environment ruled by a separate hierarchy, and motivated by profit. The home was thus re-created as the opposition to the world of work, becoming private, and organized around family and social, rather than business, connections: the home "is the place of Peace; the shelter, not only from all injury, but from all terror, doubt, and division" (Ruskin, 82). In the public consciousness of the increasingly dominant middle class, the home became the woman's sphere, the workplace the man's; more importantly, the woman became invested with the role of guardian of the home-as-refuge from the corrupting world of the market:

> The man, in his rough work in open world, must encounter all peril and trial: to him, therefore, must be the failure, the offense, the inevitable error: often he must be wounded, or subdued; often misled; and *always* hardened. But he guards the woman from all this; within his house, as ruled by her, unless she herself has sought it, need enter no danger, no temptation, no cause of error or offense. (Ruskin, 82)

The woman of the house became both a symbol, and a reward, for all of the man's hard and degrading labour, whether physical or intellectual.

This new role for women was often, in practice, subordinate to the more highly valued, male, role of making money, but it was nevertheless idealized to the point where it made a profound difference in the lives of middle- and upper-class women: in order to serve as guardians of morality and virtue, women had to be kept safe from anything that could corrupt them with the taint of the marketplace, of the world. This was especially the case in Britain, where the combination of anti-Revolutionary sentiment and the rise of the evangelical movement made the preservation of specifically English virtues a religious and patriotic duty. The pure, noble, nurturing lady of leisure was not idle: she could be kept very busy with the supervision of her household. Nevertheless, she could not do real—specifically, commercial, money-making—work, with either her hands or her mind, for fear of becoming too coarsened by a more masculine form of activity. She was trained therefore to comfort, delight, and amuse through her artistic accomplishments and fine needlework. As Nancy Armstrong and Leonard Tennenhouse argue, any work the lady did do was to be for the betterment of the home, rather than of herself; and her intellectual energies and ambitions were to be centred in the career of domestic management through the moral supervision and monitoring of herself, her children and her servants (105-6).

This ideal of the lady as domestic angel was a dominant force in shaping the education and daily lives of middle-class girls and women in the first half of the nineteenth century; nevertheless, increasing numbers of women began to question the weaknesses of the ideal's underlying arguments. The angel-in-the-house (a term coined by Coventry Patmore in his poem of the same name, published 1854-56) had actually sown the seeds of her own undoing. In conjunction with the influence of the evangelical revival, the imperative for the domestic woman to be the exemplar and teacher of virtue created some limited public occupation for her as a teacher to the young, and philanthropist to the poor. Moreover, in those cases where the ideal failed—as it seemed to do increasingly—because the lady of leisure had no wealthy husband or father to care for her, she was often forced into an occupation regardless of inclination or training: "Day by day poor and incompetent ladies ask for work, and look round in bewilderment, not knowing what to do, and being only too well aware that they can do nothing thoroughly or well . . . In these days many girls work from choice, and are far happier for so doing. In these days, too, many gently born girls work from necessity" ("Employment for Girls," 63).

More and more women came to take on new kinds of public roles, from charity to teaching and governessing; and, just as had been predicted, they were indeed affected by their contact with the outside world. For example, women who longed to do good as volunteer philanthropists discovered frustrating limitations: without education and training, salary, official recognition, or political representation, they could do little to correct the social ills they discovered outside their sheltered homes. And both governesses and their employing public discovered that the education of a lady of leisure was woefully inadequate when put into practice teaching the young, especially those future captains of industry and governors of the nation—boys. Finally, if the governess' career ended, not in marriage, but in unemployment, her drawing-room accomplishments proved to be practically useless as a means of earning a living.

Consequently, both early feminists, and more conservative upholders of the status quo, were forced to agree that reforms of female education had to take place. In 1843, the Governesses' Benevolent Association was formed, mainly to provide assistance for aged and unemployed women teachers; but it became apparent that greater assistance would have to come in the form of greater training and education. Conservative reformers were interested mainly in improving the ability of the governess—or mother—to properly instruct the young within the confines of the home; as a result, when Queen's College, the first institution for women's higher education, was formed in 1848, it was run by the Church of England and an all-male administration specifically for the education of governesses. But as more and more women became not just governesses, but teachers in the growing numbers of middle-class schools, Queen's College, and then North London Collegiate School for Girls and Cheltenham Ladies' College, began to offer a broader and more rigorous curriculum for its female students (Burstyn 23-24).

Once again, as critics of female education had feared, the more education young women received, the more they wanted, and the more they demanded opportunities to put it into practice. Moreover, changes in the economy made it harder to deny the need for at least some middle-class women to work. On the one hand, the marketplace needed new workers; on the other hand, the genteel life of leisure needed to maintain the ideal "lady" was becoming more difficult for husbands and fathers to achieve—in fact, husbands were becoming a scarce commodity themselves. W.R. Greg was only sensationalizing what was already an issue of growing concern when he wrote his influential article, "Why Are Women Redundant?" in 1862. Greg concedes that every society will always contain a certain number of women who are either so lacking in femininity or who are so exceptionally gifted that they will inevitably choose to find fulfillment elsewhere than marriage—but Nature would only tolerate a very small number of such anomalous women.

But the census of 1851 had revealed that 1.3 million women in Great Britain were unmarried. According to Greg's calculations, "the proportion of women above twenty years of age, then, who *must and ought* to be single being *six per cent*, the actual proportion who *are* single is *thirty per cent*" (282). Of these 1.5 million "redundant" women in Britain, "half a million are wanted in the colonies; half a million more are usefully, happily, and indispensibly occupied in domestic service" (306-7). The problem of redundancy was thus easily solved for working-class women who could either work as servants or emigrate; but the half-million *middle-class* women who were left over posed another difficulty. For Greg, the solution was to consult Nature (278)—and Nature's decree was apparently in favour of marriage. And to promote marriage, Greg exhorted men to give up "profligacy" (296), and women to give up a preference for independence. As far as Greg was concerned, if women were unhappily single, they ought not to try making single life attractive to themselves through the pursuit of social and economic autonomy; they ought to wait for men to reconsider natural laws and give up their profligacy in favour of marriage:

> To endeavor to make women independent of men; to multiply and facilitate their employments; to enable them to earn a separate and ample subsistence by competing with the hardier sex alone; to induct them generally into avocations, not only as interesting and beneficent, and therefore *appropriate*, but specially and definitely as *lucrative*; to surround single life for them with so smooth an entrance, and such a pleasant, ornamented, comfortable path, that marriage shall almost come to be regarded, not as their most honorable function and especial calling, but merely as one of many ways open to them, competing on equal terms with other ways for their cold and philosophic choice:—this would appear to be the aim and theory of many female reformers . . . . Few more radical or more fatal errors, we are satisfied, philanthropy has ever made. (Greg, 300)

But as Jessie Boucherett pointed out in her reply to Greg, neither emigration nor marriage could be counted on to provide for the apparently unwanted women. "Superfluous" women did not need husbands; they did not need more and continued dependence; they certainly did not need to be swept under the carpet through the less-than-ideal "solution" of emigration. What impoverished women of all classes needed, argued pragmatic reformers like Boucherett, was the same chances offered to men: to learn skills, to have access to remunerative employment, to contribute to society instead of being a drain on its resources:

> The plan then which I advocate for providing for superfluous women is that of allowing them to engage freely in all occupations suited to their strength. The great merit of this plan is, that it would put an end to superfluous women altogether, by converting them into useful members of society. This is without doubt the plan intended by nature all along, and it is from failing to fulfil it that we have fallen into such difficulties. (Boucherett, "How to Provide for Superfluous Women," 45)

Whether they agreed with this more radical solution or not, growing numbers of young women realized that the ideal of domestic security and protection was no longer within their grasp, and the public world offered more opportunities than ever before: women could not afford to stay home any longer.

Supporters of women's rights to education and work came at the problem from both sides. Josephine Butler, and lady-activists such as Barbara Leigh Smith Bodichon and Jessie Boucherett of the Langham Place set, created organizations and publications to promote women's employment. Their involvement led them naturally to support university education, the opening of the professions, and, ultimately, the opening of the political process to women as the only definite way to ensure their rights and interests. But it was Emily Davies who worked most single-mindedly to improve women's higher education. Recognizing that girls needed something to work towards, and that educational reform might be more effective if implemented from the top down, she directed her attention to the universities—the gateway to the professions, and to politics—which had historically been closed to women. In 1863, supported by the Langham Place feminists and others, Davies was able to convince Cambridge to allow girls to write its Local Examination. The uneven results of the exams, combined with the disappointing findings on the state of girls' secondary education by the Taunton Commission of 1865, added force to Davies' arguments for a more stringent curriculum for girls, and resulted in increased money, and public support for new schools.

Davies' ultimate goal became the securing of university degrees for women; if women were ever to share in the otherwise all-male realms of politics and the professions, they needed to attain the training—and, just as importantly, status—conferred by a university degree. In 1869, she arranged for women to start taking classes at Cambridge through a small institution at Hitchin which eventually became Girton College; Girton was soon joined by Newnham College. Davies next persuaded Cambridge to allow her students to write the same final exams—the Tripos—as the men, thus requiring her women students to study the traditional male curriculum with its emphasis on mathematics, Latin, and Greek. Davies was a determined opponent to separate curricula for women, believing that women's higher education would be taken seriously only if it paralleled men's exactly.

But despite the fact that girls from Girton and Newnham were succeeding in the exams, in many cases equalling or surpassing the men's scores, the university refused to grant women degrees. They would receive certificates, but were unable to call themselves BA until 1921, and were not admitted to the university's governing body until 1948. Oxford started admitting women to degree programs in 1875, but, like Cambridge, did not allow them to become degree *holders* until 1920. Nevertheless, despite the recalcitrance of the most prestigious schools, other universities did open their doors, and some of their degrees, to women in the last quarter of the nineteenth century: for example, the Manchester New College was opened to women in 1876; the University of London began admitting women to both its undergraduate and medical programs in 1878; and

Manchester's Coeducational Victoria University opened in 1884 (Levine, 55). The successful graduates, whether possessing certificates or degrees, went on to teach, to pursue careers, or to act as role models for their own daughters. Moreover, activists like Davies made the academic and professional climate more hospitable for women who wished to attempt more non-traditional, and controversial, careers such as medicine, pharmacy, and office work. It became increasingly difficult for critics of women's work and education to argue that women were not intelligent or skilled enough for such demanding careers, when they were now receiving the same education as men, and were proving themselves more than capable.

II. Aesculapius and His Daughters:
The Medical Profession and the Rise of Women Doctors

As many medical historians have pointed out, women have been involved in the practice of healing throughout history, performing the duties of nurse, apothecary, and physician within their families or villages. According to Sophia Jex-Blake, in her *Medical Women, A Thesis and History*, women's claim to formal medical education is a logical step in the evolution of what she argues is a natural role:

> If we go back to primeval times, and try to imagine the first sickness or the first injury suffered by humanity, does one instinctively feel that it must have been the man's business to seek means of healing, to try the virtues of various herbs, or to apply such rude remedies as might occur to one unused to the strange spectacle of human suffering? I think that few would maintain that such ministration would come most naturally to the man, and be instinctively avoided by the woman; indeed, I fancy that the presumption would be rather in the other direction. And what is such ministration but the germ of the future profession of medicine? (5)

And yet, despite the apparently natural claim women have on medical practice, there were no officially-recognized women doctors in England or America until the second half of the nineteenth century. The history of western medicine is long and complex, but to explain the absence of women doctors before the mid-nineteenth-century, and the hostility directed at them after their emergence, it is sufficient to begin by examining the changes which had taken place within the medical profession during the preceding hundred years.[1]

In eighteenth-century England the medical profession was disorganized, underregulated, and fragmented. University-educated physicians set themselves up at the top of the medical hierarchy, charging the highest fees for their consultations in genteel, urban homes. The physician's education was almost entirely theoretical, and still based on what late nineteenth-century practitioners would see as unscientific, Galenic principles. Nevertheless, despite the fact that these physicians had almost no reliable knowledge with which to combat disease, the fact that they had had a genteel education and did not work with their hands entitled them to the status of gentleman, rather than tradesman, allowing them more status and influence over the profession as a whole. By contrast, because surgeons worked with their hands, and with tools, and relied more for their education on an apprenticeship system, they were ranked below physicians as mere tradesmen—even though a surgeon often got better results setting bones and dislocated joints than the physician did by bleeding and purging for fevers. The apothecaries occupied a position alongside surgeons, again because their work resembled a trade more closely than did the physician's. Nevertheless, the apothecary was often more frequently consulted by the lower and middle classes, particularly in more rural areas eschewed by status-conscious physicians; as time went on, apothecaries increasingly found a demand for their medical advice, as well as for their ability to fill prescriptions.

Up until the latter half of the eighteenth century, these medical divisions competed aggressively with one another for business—for money, and for status. But one area of medical practice remained largely beyond the sphere of their influence: midwifery, or, as it later came to be formally called, obstetrics. In the area of caring for pregnant and parturient women, the midwife still held the majority of the cases. Whether she had a long career—again based on apprenticeship—providing midwifery services in her parish, or whether she was a friend or relative called in an emergency, the midwife's education and practice were based very much in the female, family-based culture of her community. But it was the very informality of the midwife's profession that led to her gradual decline: because her medical knowledge was not sufficiently differentiated from "women's work" it was easy for the male medical profession to target it as no knowledge at all.

As the eighteenth century progressed into the nineteenth, medical men began to work seriously to reform and reorganize the profession; higher standards for education and practice were the side effects to a more concerted effort to raise status and wages for the doctor. Nevertheless, the emphasis on formal education, followed by standardized exams and certification, did have an elevating effect on the profession, increasing patient/consumer confidence and their willingness to call in, and pay for, a licensed professional in times of sickness. With the increasing popularity of forceps in the later eighteenth century the victory of the man-midwife (or *accoucheur*, as he was known in fashionable circles) was almost complete. Despite the fact that forceps could cause more damage and infection than they prevented if not used judiciously, the instruments seemed to offer a more scientific, technologically advanced, option during childbirth—and their use was taught only in the all-male medical schools. British midwives continued to practise, but increasingly only among the lower classes, who could pay only the smallest of fees. Midwifery did not begin to claim professional status until the late nineteenth century, and did not receive separate professional status until the Midwives Act of 1902. Physicians, by contrast, began to thrive by attending to the obstetrical needs of the upper and upwardly-mobile classes, who were willing to pay for what appeared to be the most advanced medical care, provided by individuals whose social status better matched their own.

Male doctors made the most of their growing influence, using the popular press, professional journals, and word of mouth to highlight the contrast between the rigorously trained gentleman, able to draw on the most advanced knowledge of obstetrics and *materia medica*, with the untrained, illiterate, working- class midwife. The graduate of a medical school may never even have performed a solo delivery before launching into practice; he may have been no more observant of antiseptic procedures than his female colleagues—but he looked cleaner, more genteel, and more authoritative, and increasingly, he was called in to do what had formerly been the midwife's job.

The ousting of midwives as competitors was a major advance for medical men. Pregnancy, childbirth, and childcare provided a constant and abundant source of business, and once the doctor had cared for mother and baby, he was more likely to be called in to attend to the rest of the household. The status of the profession in general was increasing, as the respect for "science" generally increased, and the divisions between physician, surgeon, and apothecary were beginning to blur as new knowledge, and changing attitudes about the status of work, led each group to take on the tasks of the others. Medical men were now in a position to consolidate medical practice as a profession—that is, as a monopolistic control of knowledge, products and services.[2] With the passage of the British Medical Act in 1858 the role of formal, medical school education and examinations for all practitioners was made absolute. Policies were created to regulate fees, training, and discipline, all overseen by medical men themselves, rather than any independent regulatory body. Most importantly, the new British Medical Association was the only body recognized to certify doctors for government positions, and to grant practitioners the right to call themselves "doctor." But the BMA did not have firm stipulations against those with foreign degrees; and it was this small degree of latitude which allowed the first woman to join the medical register in 1859.

Although she was by birth a British citizen, Elizabeth Blackwell had received her training in the United States, where she and her family had lived since she was eleven. The medical profession in the United States was organized along different lines from its British counterpart: although medical practice had started out with the British system of divisions, it had much earlier become a more loosely-formed body, especially outside the larger urban centres of the east coast. A widely-dispersed population, based much more in rural areas, often on what was regarded as the wild frontier, had developed a certain degree of impatience with the British medical profession's class-based organization. The popular climate was much more accepting of a more democratically arranged profession, and was also much more open to alternative, or "irregular" forms of medical practice, including homeopathy, hydropathy, and Thomsonian, do-it-yourself, medicine. Moreover, without the class- and connections-based British system of education, where schools and universities were run through Church and government sponsorship from medieval times on, American schools were free to spring up wherever the market would support them, catering to whatever philosophy was most popular and profitable.

As a result, for much of the nineteenth century, the regulations surrounding medical education and certification were much more haphazard in the United States than in Britain. On the one hand, this produced many self-styled doctors, practising spurious forms of medicine; on the other hand, it was possible for women to gain admittance into reputable, and irregular, schools alike, or to set up practice after studying more informally under the tutelage of other doctors (Morantz-Sanchez, 15).[3] The inconsistencies in the American system worked to the advantage of Elizabeth Blackwell, who in 1849 had graduated from the medical school of Geneva College in the state of New York. Blackwell was a feminist, and believed in opening the professions to women; she was making a deliberate effort on their behalf when she went to England in 1859 to lecture on the subject, and to place her name in the British Medical Association Register. She was accepted by the BMA largely because her novelty was regarded as non-threatening; soon after, however, the BMA instituted a policy barring foreign degree holders from membership in a deliberate attempt to prevent "irregular" and *female* physicians from professional practice in Britain.

The first Englishwoman to find a way to successfully follow Blackwell was Elizabeth Garrett Anderson. She was initially inspired by one of Blackwell's lectures to pursue medical education herself. She began by training as a nurse, but eventually decided that since she was capable of being a doctor, she ought to attempt this more challenging goal. As she wrote to her friend and mentor Emily Davies, she told her father, "I *must* have this or something else; I cannot live without some real work" ("EG to ED, 26 June, 1860," Anderson, 1939, 46). She was rejected by the university medical schools; however, some doctors at the teaching hospital where she nursed were willing to offer her private instruction, at which she excelled. But once her knowledge surpassed that of the male medical students, capturing their attention and resentment, that program of study was closed to her. She continued to study privately as an apothecary: apothecaries by this time were almost indistinguishable from general practitioners, and although they were not called MD they were authorized to practise medicine. The apothecaries had no provision in their charter to withhold examination from candidates who had been privately instructed; nevertheless, when Anderson applied to be examined, the Society attempted to change their policy. Newson Garrett, Anderson's wealthy father, had originally been appalled by his daughter's choice of career; but by this point he was suitably convinced of her abilities, and the injustice of the obstacles placed in her way, to stand behind her. He threatened to sue, and the Society backed down: after Anderson passed her exams, she was admitted as a Licentiate in the Society of Apothecaries. More importantly, as an LSA, she was also able to join the medical Register as the first English woman doctor. No sooner had she done so, however, than this second potential back-door entrance for women was shut; from now on, only recipients of degrees from recognized, formal programs would be accepted onto the BMA's Register.

Anderson, feeling the lack of an MD as a hindrance to a more profitable and credible career, eventually decided to go to France to continue her studies at the University of Paris: this school, along with many other European schools, had recently begun accepting women. Anderson was a top student there, and graduated in 1870. The Paris MD, a foreign degree, may not have entitled its bearer to be a member of the BMA, but it did not prevent one from practicing medicine; being on the BMA register gave one official recognition, but it was still possible to practise unregistered at this point. A Paris degree's foreign status was compensated for by its prestige; a Paris degree was considered the sign of an elite medical education by both professionals and the public. Anderson was always an advocate of foreign medical study for women because of its respected status, and because the schools would actually take qualified women; as Jex-Blake reports, Anderson felt it better for women to quietly win their point of deserving study at home, by proving their fitness abroad:

> If a hundred women were practising medicine in England in a creditable manner, and were able to say that they were unregistered through no fault of their own, the injustice of the case would be felt universally, and either good foreign degrees would be made registrable, or women would be allowed to study medicine and take out a degree in England . . . I cannot but think that women can in no way better serve the cause we desire to promote than by going to Paris to study medicine, and returning here as soon as may be to practice it. 'Nothing succeeds like success;' and if we could point to a considerable number of medical women quietly making for themselves the reputation of being trustworthy and valuable members of the profession, the various forms which present opposition now takes would insensibly disappear, and arrangements would be made for providing female medical students with the advantages which it appears hopeless to look for at present in this country. (Jex-Blake, *Medical Women*, 84-85nEE1)[4]

On this point, she disagreed with her close contemporary, and the most aggressive of the campaigners for women's medical education, Sophia Jex-Blake. Jex-Blake shared the views of one of her role models, Emily Davies: Englishwomen's ability to pursue higher education and professional careers would never be taken seriously until they could prove themselves side by side with Englishmen, following the same course of studies and examinations. Women could study abroad as a temporary expedient—Jex-Blake herself studied for a time at the New England Hospital for Women and Children, and received an MD from the medical school at Berne, Switzerland in 1877—but they needed to qualify at home, and they needed to convince the universities to open their degrees to female students:

> I can imagine few things that would please our opponents better than to see one Englishwoman after another driven out of her own country to obtain medical education abroad, both because they know that, on her return after years of labour, she can claim no legal recognition whatever, and because they are equally certain that, so long as no means of education are provided at home, only a very small number of women will ever seek admission to the profession. I do not say that a woman may not be justified in going abroad for education if her circumstances make it imperative that she should as soon as possible enter upon medical practice; but I do say, and I most firmly believe, that every woman who consents to be thus exiled does more harm than can easily be calculated to the general cause of medical women in this country, and postpones indefinitely, so far as in her lies, the final and satisfactory solution of the whole question. (Jex-Blake, *Medical Women*, 85-86nEE2)

Jex-Blake, like many other early women doctors, felt compelled to live a life of service, out of a sense of duty and religious calling more than out of any financial need. As a young woman, she spent several years teaching and studying, trying to find the best outlet for her energies; in 1865, when she met Lucy Sewall, a doctor at the New England Hospital for Women and Children, she felt she had found the answer to her searches, and eagerly took up medical study. However, her father's death brought her back to her family in England, and she decided that she needed to be closer to them while still pursuing medicine; and if Jex-Blake's only option for medical school in Britain was the university system, then, she decided, the British universities would simply have to open their medical schools to women.

At first it seemed that only the university of Edinburgh would be willing to admit women to any course of study; so in 1869 Jex-Blake and a handful of other women moved there and began what turned out to be a years-long struggle against popular opinion, the medical faculty, and the university administration for the right to study medicine. Jex-Blake and the other women students found that some of their professors

> seemed to think that the fact of a woman's wishing to study medicine at all quite exempted them from the necessity of treating her with even ordinary courtesy. One medical Professor, Dr. Laycock, calmly told [Jex-Blake], when she called on him, that he 'could not imagine *any decent woman* wishing to study medicine,—as for *any lady*, that was out of the question.'(*Medical Women,* 72)

The women gradually proceeded in their studies, constantly winning small privileges—access to courses, private instruction when co-educational study was considered impossible, awards for academic achievement—only to have those victories negated by some denial elsewhere. Jex-Blake and her supporters endured harassment and personal attacks of the most offensive kind. One of the worst ordeals the women faced came when they attempted to attend extramural anatomy lectures in 1870: a mob of drunken men, "comprising some dozen of the lowest class of our fellow-students at Surgeon's Hall, with many more of the same class from the University, [and] a certain number of street rowdies," was there to greet them. The mob tried to bar the women's entrance to the lecture hall, and then did their best to interrupt the lesson, resorting at one point to "the forcible intrusion of a luckless sheep"; Dr. Handyside, the lecturer, responded by saying, "Let it remain . . . it has more sense than those who sent it here" (*Medical Women*, 92-93).

Fortunately, not all the men present were hostile to the women—or if they did object to the women's presence, they were gentlemen enough to believe in a fair fight. At the end of the lecture, and for the next several days while the other men's riotous harassment continued, the women students had a safe escort home, arriving at the lodgings "with no further injuries than those inflicted on our dresses by the mud hurled at us by our chivalrous foes" (93).[5]

The women students had to fit their studies in among a never-ending stream of protest activities; they were constantly engaged in letter-writing campaigns, fund-raising, and protests before an endless series of university senate meetings. Not surprisingly, when Jex-Blake finally did write her exams, she failed on her first attempt—although many of the other women made award-winning performances. But their persistence had only limited results, and finally, in 1874 the women were forced to give up on their efforts to obtain degrees from Edinburgh. The University had won the legal battle to deny the women the right to graduate, despite allowing them to study, and pay fees, for the previous five years. The women then chose a new plan. In 1877 they and their supporters opened their own school, the London School of Medicine for Women; the school subsequently became affiliated with London University, which in 1878 became willing to open its degrees, including medicine, to women. The women's supporters also pursued legislative angles; the most successful approach targeted the medical examining boards' refusal to examine women; the Enabling Act of 1877 was a limited victory in its statement "that there were no legal barriers to the . . . boards granting licenses to women. The exclusion of women from any medical school or licensing body continued to be perfectly legal" (Blake, 184). At about the same time, the King's and Queen's College of Physicians of Ireland also announced its willingness to recognize women doctors on its Register, which would allow women to practise with the same privileges as those granted by the BMA. By 1877, then, Jex-Blake, with her Berne MD, was able to join other women candidates in qualifying for degrees from the King's and Queen's College of Physicians of Ireland; she then turned her attentions to running the London School of Medicine, with Elizabeth Garrett Anderson and Elizabeth Blackwell as members of the faculty. In 1878, London University opened its degrees—including medicine—to women, and by 1880 women were finally admitted to the BMA register. But while it seemed as though the battle for education and accreditation had been won, the real battle, for professional and public acceptance, was far from over.

III. Temperatures Rising: Private Decisions Become Political and Public

In spite of—indeed, often because of—the advances made by early pioneers, significant obstacles and objections to women's pursuit of education and careers remained. The choices of the individual were seen as inseparable from the interests of the society, and consequently, no matter what degree of involvement they could claim in the issue, many people made it their business to comment on the fitness of Woman for work and study. The result was a long-running dialogue between anti-feminists and their feminist opponents, as they fired textual volleys at one another on the subject of female emancipation in general, and, as one of the movement's most visible embodiments, the woman doctor in particular. The battleground for this debate was the media, especially popular periodicals and novels. The Woman Question was not the only topic discussed in print; after perusing the pages of many of the popular magazines of the day, one quickly notices that then, as now, public interest ranged over a variety of issues and subjects. But since women were making news with new demands and accomplishments on a recurring basis, there was always something to say about the possible consequences for social order and English decency if the strong-minded women were to have their way.

Many writers critical of feminist challenges to the status quo found that the most effective objections they could raise were based less on logic than on a circular use of emotion and sentimental idealism, appealing to the dictates of tradition, decorum, and Nature. They argued that women were meant to be different from men; without inquiring too closely into how it came to be that men were stronger and more aggressive, the providers and protectors, they assumed that it was only natural that women should complement these qualities. John Ruskin's 1864 essay "Of Queens' Gardens" is often cited as encapsulating this view of the sexes' proper spheres:

> The man's power is active, progressive, defensive. He is eminently the doer, the creator, the discoverer, the defender. His intellect is for speculation and invention: his energy for adventure, for war, and for conquest, wherever war is just, wherever conquest necessary. But the woman's power is for rule, not for battle,—and her intellect is not for invention or creation, but for sweet ordering, arrangement, and decision. She sees the qualities of things, their claims and their places. Her great function is Praise: she enters into no contest, but infallibly judges the crown of contest. By her office, and place, she is protected from all danger and temptation. (Ruskin, 81-82)

As Weltman points out, Ruskin's vision of complementarity was ideally supposed to give women a degree of power and responsibility to match that of men. He accorded them the queenly power of commanding men, to apply the civilizing influence of their domestic and moral authority to a concept of the home, the "Queens' Gardens," which encompassed "all of England" (Weltman, 119).

However, while Ruskin's theory of complementarity obligates women to use their powers to influence men, the possibility of women actually taking on male power and authority is not raised as a desirable option. Weltman observes that Ruskin's views are far more liberating for women than those of another oft-quoted commentator on the roles of the sexes, Coventry Patmore. Patmore's ideal woman, portrayed in his poem *The Angel in the House* (1854-56), achieves her perfection through acknowledged weakness and inferiority (Weltman, 113-14) . By contrast, Ruskin elevates his ideal woman to the superior status of Queen, as powerful, in her own realm, as Victoria is in hers; of course, Victoria's powers as Queen were largely symbolic, compared to the legislative power of an all-male

Parliament (Weltman 114-15). Thus, Ruskin's queenly woman, for all influence, is still relegated to a position on the sidelines of life's battles; the actual strife, and the actual victories, are, through a natural division of powers, left to the men.

Thus, while Ruskin's complementary theory of sex relations could be, and was, used to defend women's rights to increased public involvement, it could also be employed to argue against women's claims, on the grounds that feminist demands overstepped and upset the natural and harmonious arrangement of separate spheres. Many who made use of the idea of complementarity to argue against feminism often tended to oversimplify the principle; the consequence of moral and rhetorical clarity was a tendency towards a too-rigid codification of gender roles, that justified the interpretation of the ideal into a practice that constrained both its male and its female members. Complementarity seemed in these arguments to lead inevitably to a view of sexual relations based on opposition and polarity, turning women's strengths into weakness and passivity, and creating further divisiveness between the separate spheres of women's and men's labour. The proof for the merits of this oppositional view was society just as it was, or at least, just as it was idealized to be. Such *post hoc* reasoning came both from those who still believed in a providentially-ordered universe of natural laws, as well as those who interpreted new scientific discoveries through a conservative and yet triumphant optimism about Victorian civilization's place at the pinnacle of evolutionary and social progress.

To these critics, female emancipation in terms of education, work, or politics, was a sure recipe for the degradation of British society:

> . . . society, which is now very ancient, has from experience formed a code of laws for its own regulation, from which it would be highly inexpedient to deviate . . . by the common consent of mankind in all ages, certain vocations have been assigned to each of the sexes, as their proper and legitimate sphere of action and utility—and . . . any attempted readjustment

> of these could lead to nothing save hopeless error and confusion . . . .
> (Aytoun, 198)

Female ambition was a sure path to anarchy. As Linda Dowling suggests, the New Woman—one embodiment of feminism—was regularly associated with the contemporary decadent movement in art and literature, because both seemed to "quarrel with established culture" (437). Extrapolating the behaviour of all emancipated women from the actions of a few radical portrayals in the New Woman fiction, many critics feared that "the New Woman, in her hypermodernity, her ambitious attempt to transcend established notions of sexual consciousness and behavior, would irreversibly unfit herself for her essential role as wife and mother—that, in short, she would follow the decadent down the road to personal, and ultimately, racial extinction" (Dowling, 446).

The barriers that separated men's work from women's helped to define the middle class; so to cross gender lines was to threaten class stability as well. Thus, the woman who pursued a man's course of studies would be no woman at all; or rather, she might nominally be a woman, but she could not be a *lady*. She would neglect the natural, womanly arts of middle-class domestic management and supervision, so that if she ever married, she would be incapable of providing her husband with well-prepared food, comfort, and household order. And if her studies led to the pursuit of a profession, she might neglect her family altogether; her contact with the cares of the outside world would destroy her modesty and purity of mind, coarsening her and making her unfit to care for and educate her children, if indeed she would even be bothered to fulfill her duties as a wife and continuer of the race:

> The true happiness and wellbeing of women is to be found in their performance of domestic duties. Whatever tends to that is wise, meritorious, and good. But to make women wholly independent, which is the real object of the present agitation, implies an inversion of the laws of nature, which is simply impossible and absurd. (Aytoun, 201)

Marriage and motherhood were seen as the only cure for the "fast" behaviour that was so prevalent in fast times for those idle young things characterized by Eliza Lynn Linton and others as Girls of the Period. But if feminists—Linton's "Wild Women"—had their way and all women went off to college, and then to the office or hospital ward, there might be no limit to their resultant shamelessness. Observers like Linton constructed an emotional equation whereby emancipation, caused by self-indulgence, led to a loss of womanly virtues, which would in turn undermine all virtue: "When women are bad, all is bad. Their vice poisons society at its roots, and their low estimate of morality makes virtue impossible" (Linton, 143).

Women doctors were seen to run a special risk for becoming corrupted and unsexed by unnatural and vicious excesses of education and independence. Fears of the corrupting influence of medicine in particular are perhaps more understandable when one considers just how crude and, indeed, violent, medical practice was for much of the nineteenth century. With antisepsis, anaesthesia, diagnosis, and treatment all in what we would today consider a rudimentary form, life in hospital could be very harrowing indeed, as doctors were exposed to the absolute worst sights and smells of the diseased or injured body. Moreover, as doctors, women could not be protected from knowledge of all manner of human behaviours which might otherwise by screened from them by a life of middle-class domesticity. Crossing over into the public sphere, women doctors would, like their male counterparts, see the effects of prostitution, vice, ignorance, and poverty close up.

As many feminists pointed out, this was a problem only because it was middle-class ladies who proposed to become doctors. For women willing to work as nurses in the wake of Nightingale's reforms, the same workplace exposure was not considered to have any ill effects: if the women were working for an inadequate salary, then they were working-class, and so their modesty and delicacy were not at issue. If a woman was a lady-nurse, coming from the upper classes, her salary, if she even accepted one, was of no consequence, compared to the purely altruistic and self-sacrificing motives which were supposed to have brought her to toil at the bedside of those less fortunate, under the supervisory gaze of the male doctor. But the woman doctor was a different case. She might be a lady, but unlike the nurse, she was presumed to be motivated by more motives then charity: only a woman with ambitions would find the nurse's role unsatisfactory. But such ambitions for knowledge, independence, professional prestige, and respect were seen as proof of the unnatural effects of too much study and work, especially of the medical kind, and the more a young lady worked, the worse her unnatural cravings would become, taking the place of her more delicate, refined sensibilities. Such sensibilities could be fostered only in a pure, because sheltered and sterile, environment—and a medical school was certainly no such place.

Because of the brutality of their working conditions, it was not too surprising that the study of medicine fostered a culture of brutal and crude behaviour in its male medical students—a fact which was well known enough that it often lies behind many specific objections to women's practising medicine. If gentlemen sometimes had to sacrifice refinement in order to get the job done, how could ladies avoid having to do the same thing? And yet, for a lady to lose her refinement was to lose the very delicate weakness and sensitivity against which middle-class male strength was delineated: if femininity was lost, and logical extremes were allowed to obtain, it was tacitly understood that masculinity, the middle class, and British nationhood, would somehow follow.

Alison Bashford, in *Purity and Pollution: Gender, Embodiment and Victorian Medicine,* offers a convincing argument for the extremely complex nature of the anxiety surrounding the presence of women medical students in the wards and dissection labs (see especially Chapter 6, "Dissecting the Feminine: Women Doctors and Dead Bodies in the Late Nineteenth Century"). The problem with dissection in particular was that for male scientists and doctors it was, from the beginning, "a profoundly unstable and culturally precarious practice" (108), for a variety of reasons including the violence involved, and the incursion of secular science into what had previously been religious territory. Building on the work of Ludmila Jordanova's *Sexual Visions: Images of Gender in Science and Medicine Between the Eighteenth and Twentieth Centuries,* Bashford emphasizes that a central motive or justification behind dissection was the idea of a feminized Nature unveiling her mysteries for the gaze of masculine science. Jordanova uses an analysis of ninteenth-century artwork by artists such as John Wilkes Brodnax and Gabriel Max, featuring male doctors and scientists dissecting female cadavers, to demonstrate this point:

> Men strive to "know" women in the biblical sense, just as the natural sciences continually aim to penetrate nature's mysteries. The other is simultaneously veiled, that is mysterious, threatening and separate, and to be unveiled, that is mastered by seeing and knowing. The process of unveiling is called science . . . Medicine, like science, was based on the unveiling of nature. Woman, as the personification of science, was the appropriate corpse for anatomy, which was not just literally male in that its exponents were men, but was symbolically male in that science was also the masculine practice of looking, analysing and interpreting. (Jordanova, 110)

Thus dissector/cadaver relationships were always "sexed"; even though cadavers were, in actual practice, often male, they were thought of, even idealized as feminine, or at least feminized. As Bashford explains, the binaries implied in this relationship were complicated by additional oppositions between inside/outside, penetrated/penetrator—again, linked to the division between female and male. And on top of the barriers imposed by these oppositional relationships, Bashford also identifies the female body as the site of tension between purity and pollution: the woman was potentially the source of both. So for women to dissect was to cross a number of barriers used to define order in a gendered society. For women to go further and dissect male cadavers, and then use their knowledge to treat live male patients, was to turn the order completely upside down, and remind male practitioners of just how unstable the order had been in the first place. Woman would take on the masculine privilege of the scientific gaze, becoming the knife-wielding penetrator of a feminized male object. Such objectification not only implied a loss of power for men's sense of their own masculine role in society, it also suggested their inability to control women, and by extension, purity and pollution, order and disorder, in society at large.[6]

Thus, commentators shuddered verbally at the thought of young ladies crossing the line into the realm of impropriety and chaos, as this Special Correspondent from Paris demonstrates in describing the sight of a young woman—"I cannot bring myself to say a young lady"—dissecting a female cadaver alongside male medical students: "A punning friend, when there with me the other day, said—pointing to [the instructor, Professor Fort]—'C'est Fort'; and then added—pointing to the mixed dissecting group—'Et c'est trop fort'; and another of our party added, 'Et le tout est dégoutant'" ("Special Correspondence from Paris" *BMJ*, 586).

Many observers found it inconceivable that women—ladies—could be exposed to the naked human body, even more naked in its decay, and still maintain their delicacy throughout the normal course of medical study: "How could one whisper a soft nothing to an ear that had been hardened by the chaff of medical students and the language of the schools: or how could one press tenderly the fingers which had just been spreading a big blister, or dispensing a black dose?" ("A Foul Word for the Fair Sex," 203). And if such scenes were not disturbing enough because of the shockingly unsexed behaviour of the women, worse still was the prospect of long hours spent studying with men. Even if the students were ladies and gentlemen (there were often no guarantees for the latter), such constant contact was certain to tempt even the most pure into improper relationships:

> The majority of right-thinking persons will at once feel that condiscipular community of young men and young women in medical studies must mutually deteriorate both. As to the latter, the mischief will probably be limited to a few persons; but in respect of the great mass of medical aspirants, the damage will be universal; they will become indelicate and

> coarse; they will be apt to regard their female patients as equally seared with their female fellow-students. That, surely, is no light matter; for can any one be more pitilessly unsexed than the young woman who has been lectured to, and demonstratively taught the science and art of medicine, in company with young men? Impossible. ("Note from Paris Correspondent," *BMJ*, May 28, 1870, 559)

Real-life medical students like Elizabeth Blackwell, Sophia Jex-Blake, and Elizabeth Garrett quickly discovered that they had nothing to fear from decaying, but unmistakably male, cadavers; nor did the women themselves pose any kind of threat, either to themselves or to their male classmates and professors. The atmosphere of the anatomy lecture or lab was coarse and disgusting, but the cause was not the mute, but fascinating, specimens for dissection; nor was it some inherent moral impurity brought into the room by the women themselves. The real danger—or more precisely, the real, exasperating annoyance—was the crude, childish jokes permitted in the classroom "where [the] respected professor meanly takes advantage of his position as . . . teacher to elicit [the students'] mirth and applause, to arouse their jealousy and opposition, by directing unmanly innuendoes at the lady students" ("Vir," qtd. in Jex-Blake, *Medical Women* 67nQ). But in those cases where the women persisted in sharing the classroom with men, and were granted the opportunity to do so, many men admitted—often with gratitude—that rather than being lowered to a disgusting level by the subject-matter, the lady-students had an elevating effect on the whole moral tone of the school:

> We believe, indeed, that nothing could be more desirable for the average young medical student than to find himself associated in daily study with women whom he cannot but respect; nothing more calculated to give him an earnest sense alike of the dignity and of the purity of his vocation than to labour in it side by side with ladies whose character and whose motives are to him a daily reminder that he and they alike are set apart both as the

> votaries of science and the ministers of suffering humanity. (qtd. in Jex-Blake, *Medical Women*, 56nF)

The threat posed to ladylike delicacy and womanliness by work and study was not merely a social phenomenon; the process of becoming "unsexed"—losing the sharp, essential distinction between femininity and masculinity—was thought to take place at the empirically-observable biological level as well. Many medical men felt compelled by concern for the health of society's most precious and delicate resources to step into the fray of the Woman Question and offer what appeared to be incontrovertible scientific proof about the dangers of ladies straying outside of their womanly sphere. As Morantz-Sanchez has suggested, male doctors and scientists were able to make the Woman Question a medical question because, as religious authority lost much of its former power to determine vice from virtue according to the law of God, society looked increasingly to science to provide guidance and reassurance based on the laws of Nature:

> Especially in the latter half of the century, when ministerial authority declined and increasing secularization enshrined science as a new touchstone for truth, physicians, who wrote much of the prescriptive literature regarding health, sexuality, and gender roles, gave voice to traditional definitions of femininity which limited women's social role to domesticity.(205)

And the medical profession was happy to fill this role of scientific and moral authority, as it only served to consolidate its own monopolistic place in both society and the economy. Nevertheless, although medical professionals increasingly took it upon themselves to speak as the voice of nature and science, by no stretch of the imagination did this mean that they could prove what nature in fact intended. Medical science was by modern standards woefully unscientific. While the scientific method of rigorous proof through repeated experimentation was becoming more and more refined, the older, Galenic models based on deductive principles allowed scientific data to be liberally interpreted by inference and supposition. And yet, cloaked in the guise of biological and medical explanations, arguments and pronouncements produced out of this subjective practice nevertheless carried a great deal of weight in the public mind, and were a serious obstacle to those arguing in favour of new directions for women's intellectual development.

For example, in the late nineteenth century, the precise functions of the uterus were largely unknown—hormones were not understood until the twentieth century—and yet many members of the medical establishment still felt perfectly confident in characterizing all female physiology as being tied to the uterus and reproduction. Both male and female bodies were seen as closed systems, with the vital energies being properly directed to the respective sex's essential functions, which in women were seen to be reproduction; men were to reproduce too, but they were allotted more energy for intellectual work as well. Thus for a woman to study too much, or take too much exercise or improper stimulation of any kind, was to divert vital energy from her reproductive capacity. Respected medical men like William Acton, Edward H. Clarke, Henry Maudsley, and others all maintained that rigorous intellectual work—the sort required for success at university, or in the professions—was detrimental to the health of the young woman: "The energy of a human body being a definite and not inexhaustible quantity, can it bear, without injury, an excessive mental drain as well as the natural physical drain which is so great at this time? Or will the profit of the one be to the detriment of the other?" (Maudsley, 5). This deprivation would stunt the development of a young woman's feminine characteristics, resulting in an orientation towards unwomanly thoughts and behaviour and a masculine, angular appearance:

> If in adolescence, before the bones are knit, and the growth completed, and the feminine nature far advanced toward perfection, if the brain that is in the process of doing all these things is year by year called on to exert its yet imperfect forces chiefly in acquiring book-knowledge by long hours of study, and in consequence the growth is stopped, the blood, the cheeks are

> pallid, the fate destroyed, the wondrous forces and faculties . . . are arrested before they attain completion, then, when the period of growth and development ceases, the damage is irreparable. (Clouston, 223)

Moreover, even if a woman could preserve her womanliness in spite of improper education, she would still be disqualified from competing academically and professionally with men because of her essentially different biological make-up: " . . . during the period of rapid development, that is, from fourteen to eighteen, a girl should not study as many hours a day as a boy . . . during every fourth week, there should be a remission, and sometimes an intermission, of both study and exercise" (Clarke, 154-57). Female "periodicity" would automatically result in her being indisposed for one week each month, during which time she would need rest and freedom from over-stimulation, thus making it impossible for her to adhere to the regular requirements and responsibilities of the marketplace. Working during this fragile time would certainly be detrimental, not only to her own health, but to the health of others with whom she might have to associate. Dr. Horatio Storer, for example, feared that women doctors—who could make "most agreeable and charming attendants" under normal conditions (100n1)—would be more likely to perform abortions, in large part due to the deranging influence of their "often infirmity":

> . . . granting that women in exceptional cases may have all the courage, tact, ability, pecuniary means, education, and patience necessary to fit persons for the cares and responsibilities of professional life, they still are and must be subject to the periodical infirmity of their sex; which for the time, and in every case, however unattended by physical suffering, unfits them for any responsible effort of mind, and in many cases of body also. It is not to women as physicians we would object; . . . but to their often infirmity, during which neither life nor limb submitted to them would be as safe as at other times. We could hardly allow a female physician convicted of criminal abortion, the plea that the act was committed during the

> temporary insanity of her menstruation; and yet at such times a woman is undoubtedly more prone than men to commit any unusual or outrageous act. (Storer, *Criminal Abortion*, 100n1)

And finally, if the educated career woman still retained enough femininity to marry and have children, she would, of course, also have to remove herself from work for the duration of her confinement:

> Let us suppose a female barrister in large and lucrative practice, specially retained to lead in a case of the utmost magnitude upon the circuit. The day arrives—the Judge takes his seat—the list of jurors is called over. How is this? The hour of trial is past, and yet there is no appearance of our learned sister. In her place arises a stuttering animal of a junior . . . and the purport of his announcement is that he has received a letter from a gentleman in the obstetric line, stating, upon soul and conscience, that the fair pleader is in such a situation that she cannot possibly appear in Court for at least six weeks to come. In short, instead of delivering herself of a speech, she is about to be delivered of a baby! (Aytoun, 194)[7]

When it came to education and work, then, women just could not win within this physiological line of reasoning: if they could compete equally with men then surely they were too mannish themselves to be anything but repugnant to men and women alike; if they retained their femininity, it would always prevent them from competing equally in the academy or the marketplace. The separate spheres ideology was hermetic in its logic, and, on its surface, meant to be irreproachable because of its professed motivation to preserve social and national interests. However, many of the most morally elevated arguments—exalting women only to confine their ambitions—were actually based on a deeper, more irrational belief in women's inferiority:

> In the domain of pure intellect it is doubtful if women have contributed one profound original idea of the slightest permanent value to the world! Not

> only as thinkers, but as workers, are men pre-eminent . . . So little demand is there for the direct assistance of woman in the mental departments which are the special province of man, that could all the male intellect in the world be suddenly paralyzed or annihilated, there is not sufficient development of the abstract principles of justice, morality, truth, or of causality and inventive power in the female sex, to hold the mechanism of society together for one week. (J. McGrigor Allan, ccx)

While the converted to whom such arguments were preached may have found statements like the above to be obvious, it was equally obvious to feminists—male and female alike—that one half of humanity would always be deprived of its rights, and responsibilities, as long as it remained unorganized and silent. Mrs. E.B. Duffey, criticizing Clarke's arguments on periodicity, speaks for the many women who saw through the social and physiological arguments for woman's special talents and needs as simply reinforcing their role as the non-competitive, non-threatening, inferior sex:

> He [Clarke] knows if he succeeds in carrying the points which he attempts, and convinces the world that woman is a 'sexual' creature alone, subject to and ruled by 'periodic tides,' the battle is won for those who oppose the advancement of woman—the doors not only of education but of labor and any kind of physical and intellectual advancement are closed against her. He knows that labor is valued only as it is continuous and reliable, and that if women can be persuaded to become unreliable on principle, there is an end to the competition between the sexes in every department of employment. (Duffy, 117-18)

Consequently, in reply to the various social, religious and physiological arguments used to keep women trapped on their narrow pedestal, feminists countered by attempting to reveal the specious and fallacious logic used by their accusers; at the same time, these feminist rebuttals also show a tendency to uphold certain ideas about the essential nature of the sexes that the women themselves were not ready to abandon, at least not in print. On the surface, the fundamental problem seemed to be the unsexing effect of study and work; many feminists therefore tried to portray intellectual and physical exercise, professionalism, and independence, as being inherently beneficial to the cultivation of womanliness in young ladies: a womanly woman was a strong, competent, useful woman. Late nineteenth-century feminists began by building on arguments set out decades earlier by writers such as Mary Wollstonecraft, Hannah More, and John Stuart Mill: by restricting the curriculum for a young girl's study to superficial knowledge and drawing-room accomplishments, parents and educators were training their charges to be weak, dependent, and useless. Such women would be unfit companions for their husbands, unfit managers of their households, and unfit to educate their own children in either intellectual or moral matters. How could a woman uphold the most cherished domestic virtues if she did not have an intellect well-trained enough to understand what domestic virtues were?:

> The habits of reason, the habits of mental order, the chastened and refined love of beauty, above all, that dignified kind of loving care which is never intrusive, never fussy, but yet ever present, calm, bright, and sweet; all this does not come without a culture which mere domesticity can never attain . . . The woman, by being *nothing* but a domestic being, has failed to be truly domestic. She has lost the power of ministering to the higher wants of those nearest to her, by over-devotion to the ministry of their lower necessities. To be truly the "Angel in the House," she must have kept, and oftentimes used, the wings which should lift her *above* the house, and all things in it. (Cobbe, 12-14)

If, reformers argued, education and emancipation could make a boy into a man—a gentleman—it should offer the same improving qualities to young ladies, expanding their capacity for noble, moral, action, both within and without the home:

> Whatever has been said or written . . . of the ennobling influence of free government—the nerve and spring which it gives to all the faculties, the larger and higher objects which it presents to the intellect and feelings, the more unselfish public spirit, and the calmer and broader views of duty, that it engenders, and the generally loftier platform on which it elevates the individual as a moral, spiritual, and social being—is every particle as true of women as of men. (Mill, 124)

And if emancipation would benefit manliness both inside and outside of the domestic sphere, by the same token, womanliness would only flourish if given a larger scope of influence, too. As many feminists pointed out, womanliness could be no good if it were only a cloistered virtue, especially since, in practice, few women could actually count on leading cloistered, protected lives. For example, training a woman to be a wife and mother was all very well, only so long as that role was indeed available to her, and only so long as her co-star—her husband—was willing and able to play his role appropriately too. If anti-feminists knew about the varied, and often less-than-ideal reality of middle-class life, they were not admitting to it in their arguments; many feminists, though, were committed to a more pragmatic view of real life, having recognized, through their own experiences and or those of others they met in their political and philanthropic work, that financial hardship and personal degradation loomed over many women of all classes, married or not, when they had no useful skills with which to fend for themselves. Poverty and abuse were far more unsexing—because dehumanizing—than honest work. Millicent Garrett Fawcett reported in 1891 the words of a nail-and-chain-making woman who summed up the hard reality: "My work didn't hurt me: if I hadn't done it, what my mouth missed would have hurt me" (Fawcett, "The Emancipation of Women," 679).

Only the most radical women of the late nineteenth century (Olive Schreiner, for example) maintained that all of the divisions between the sexes were false and arbitrary; most feminists left unchallenged the assumption that women were different from men, with different aptitudes as ordained by God, or Nature. But they then argued that different did not necessarily mean inferior; nor did it mean that women could not work side by side with men, each bringing to the work those skills and talents unique to his or her respective sex. Again, such work allowed women to perfect their feminine abilities, rather than to waste them in idleness. For example, women were naturally better suited to fine, detailed work because of their supposedly smaller and more delicate hands—thus they were well qualified for clerical work like typing or telephone operation, or for medical work like ophthalmology. A man's psychological strength was thought to come from his natural role as protector of the weak; feminists argued that women possessed an equal degree of strength, fostered by their natural role as caregivers and nurturers—and both kinds of strength had a valuable place in the realms of medicine, social work, or the ministry.

Feminist reformers could rely on logic and common-sense to refute the emotionally-laden social and religious, or quasi-religious arguments of their opponents; but in order to successfully combat the scientific "evidence" against expanding women's opportunities, it was necessary for feminists to back reason up with equally—or more—credible scientific facts of their own. Not surprisingly, then, it was one of the first self-appointed tasks of the earliest women doctors to bring their medical knowledge to bear on the charges that too much work and study had an unhealthy, unsexing effect on women's health.

Mary Putnam Jacobi's 1877 study on "The Question of Rest for Women During Menstruation" concluded that while rest was beneficial for girls during their studies, the periodicity of their female physiology should nevertheless not prove an obstacle to pursuing an advanced education. Elizabeth Garrett Anderson concurred with Jacobi in her findings that biology would not interfere greatly with a career; physical exertion seemed to have no ill effects on the maternal capacities of working class women, who had to endure conditions much more demanding than those of their more privileged counterparts working as students, doctors, or clerks. And as for taking time off to rest once a month, once again, the example of the hard-working lower-class woman made such a proposition ludicrous:

> It is, we are convinced, a great exaggeration to imply that women of average health are periodically incapacitated from serious work by the facts of their organization. Among poor women, where all the available strength is spent upon manual labour, the daily work goes on without intermission, and, as a rule, without ill effects . . . With regard to mental work it is within the experience of many women that that which [male experts speak of] as an occasion of weakness, if not of temporary prostration, is either not felt to be such or is even recognized as an aid, the nervous and mental power being in many cases greater at those times than at any other. This is confirmed by what is observed when this function is prematurely checked, or comes naturally to an end. In either case its absence usually gives rise to a condition of nervous weakness unknown while the regularity of the function was maintained. (Anderson, "Sex in Mind and Education: A Reply," 585)

Many feminists realized that while of course middle class women like themselves were far more refined than the average female labourer, and consequently intended for more refined work in life, female physiology was more or less the same across class lines, and in all cases exhibited a very satisfactory capacity for hard work. Moreover, medical women like Mary Putnam Jacobi and the team of Emily Pope, C. Augusta Pope, and Emma Call, demonstrated that working women in both the labouring and professional classes actually had a lowered incidence of illness and monthly indisposition than those who did not work, and that women who continued the program of study and physical activity established in the more progressive girls' schools and colleges enjoyed long-lasting health benefits. Their medical claims were reinforced by anecdotal evidence from schools that were actually trying the experiment of reformed education for girls, including a number of American institutions, as Dorothea Beale observed:

> It can be shown that where the granting of degrees upon a large scale has been tried, the health of the graduates, and the average duration of life, has been above the average. There are now forty-six colleges in America, where the education of the students, men and women, is carried on together . . . Taking the average of death-rate of graduates for thirty years in seven large colleges for men, and comparing it with one of the largest female colleges, Holyoke—a college which has graduated nearly fifteen hundred students—we find . . . the life of the women graduates is longer than that of the men graduates from six out of seven of these colleges. The attendance list shows, too, that the absence from lectures of the women students in most colleges differs only by a fraction from that of the men. ("University Examinations for Women," 480-81)

Pope, Pope, and Call found that women doctors seemed to find study and work particularly congenial; in their 1881 study of 430 women medical school graduates *(The Practice of Medicine by Women in the US)*, they found that only thirteen reported ill health, and only thirty-four of 307 mentioned any specifically monthly indispositions.

Finally, the fact that many women students (including feminist icons Elizabeth Garrett Anderson, and Mary Putnam Jacobi) went on to marry and have children—either in conjunction with a career or not—demonstrated further that academic or professional achievement posed no real threat to women's health or biologically-ordained femininity. An 1880 survey of female medical school graduates done by Rachel Bodley, Dean of the Woman's Medical College of Pennsylvania, found that 129 out of 189 respondents were married ("Educated Woman," 150-51). In fact, as Morantz-Sanchez notes, medical women as a group were more likely to marry than other professional women in the late nineteenth and early twentieth centuries, despite having one of the most demanding courses of study and work (135).[8]

As to the charges that women's minds were simply inferior, the result of a smaller brain mass and a predisposition to over-sensitivity, the best reply to this came from the examples of women who had excelled in their chosen fields in spite of the obstacles. Women who had undergone an arduous course of study, and then established reputations as competent and talented practitioners, whether of medicine, education, or accounting, were living proof that women could succeed, given a fair field and no favour (as the saying went). Women such as Elizabeth Garrett Anderson and Mary Putnam Jacobi were held up as exemplars of all that a woman could do, and still preserve her femininity and ladylike ways.

These role models were extremely aware of their positions as such, and made it a point to present the most womanly public image possible. They were conscious of the need to behave with extreme self-control and dignity; it was worth risking the appearance of humourlessness, if it meant being treated with respect by their potential colleagues. Women doctors were well aware that they were expected to become coarse, unsexed, and mannish as a result of their studies, and so made it a point to maintain their feminine, womanly decorum as much as possible, while still being firm in their determination to share a quality education with men. Elizabeth Garrett Anderson, for example, was known for always being well and fashionably dressed: "Experience is modifying my notions about the most suitable style of dress for me to wear at the hospital. I feel confident now that one is helped rather than hindered by being as much like a lady as lies in one's power" ("EG to ED, 5 Sept., 1860," Anderson, 1939, 63). At the same time, medical women were also very conscious not to appear *too* feminine—that is, frivolous; uncertain as to what might strike patients or colleagues as disturbingly mannish—or girlish—many opted for conservative dress ("Bloomerism" was a "don't") that attracted as little notice as possible (Morantz-Sanchez, 121).

Concern for their femininity—or the supposed lack of it—followed women out of medical school and into practice; again, many women doctors made a conscious effort to demonstrate to their patients and public that medicine had not unsexed them, nor led them into improper or inappropriate fields of work and study:

> In studying medicine, we desire to be not in one single instance less womanly; we would not lose one iota of the purity of mind, the delicacy of thought, and the gentleness of manner essential to the ideal of womahood, and we hold ourselves capable, supported by a "clear motive of duty," and, in many instances, by a strong enthusiasm, of passing through the dissecting-room, the clinical lecture, and the pathological laboratory, not only untainted, but strengthened, ready to face the difficult questions of life and to take our share in solving them . . . We claim for ourselves, and we are ready to work for, the highest development, intellectual and moral, that is possible, and to us can safely be left the guardianship of our own womanhood. ("A Lady Medical Student," *BMJ*, September 16, 1876, 382)

In addition to putting a suitably feminine face—and dress—forward, most women doctors further safe-guarded their ladylike and womanly reputation by pointedly treating only women and children. Far from abusing the privileges of medical authority to seduce wealthy men, and indulge prurient interests with male patients—as they were accused of wanting to do—women doctors protected their own modesty and delicacy by championing the modesty of their female patients. Supporters of the medical women's movement used this as the prime argument in favour of female physicians: whether refined ladies, or lower-class labourers, all women stood to lose their privacy, dignity, and purity when subjected to the unsympathetic gaze of the male doctor. This was a real problem in the teaching hospitals, where lower-class female patients would be thronged by hoards of coarse, joking young men. Even worse was the idea of subjecting young, unmarried—i.e., sexually uninitiated—girls to the investigations of older, more experienced male doctors: "Many a time have I stood by the bedside of poor girls who seemed ready to sink under the shame of being exposed before a number of young men—a feeling which could not be overcome even by the agony of the operations" ("A Medical Student," qtd. in Jex-Blake, *Medical Women* 52nB).

Medical women and their supporters argued that even the most sensitive and discreet man could never understand women's problems, or women's delicacy, as well as a refined, womanly, lady-doctor. As a result, they argued, many women suffered needlessly because they were too mortified to see a male doctor, often delaying seeking treatment until their cases were fatally advanced:

> . . . I found four women seriously out of health; not so seriously, however, but that they might have been cured by timely medical advice. I urged each of them more than once to go to the Dispensary, but all persistently refused, each of them saying in different words that, if ladies were doctors, as they had heard they were in some places, they would have had medical advice long before. The feelings of these poor women were so strong on the subject that I found it was useless to urge them further. It seems only just and reasonable that qualified medical attendants should be within the reach of those who either have a strong preference for [them], or who will not avail themselves of any other. ("A District Visitor," qtd. in Jex-Blake, *Medical Women* 52nB).

Thus, the need for women doctors was great, and the nature of this vital work greatly reinforced the womanliness of its practitioners. And once female medical students revealed the shockingly vulgar jokes and innuendoes that spiced up the medical lectures in the schools—delivered by the same male doctors and students who questioned the women students' morals—the cause received an infusion of public support and renewed commitment: "When we came in contact with such unexpected depths of moral grossness and brutality, we had burnt into our minds the strongest possible conviction that if such things were possible in the medical profession, women must, at any cost, force their way into it, for the sake of their sisters, who might otherwise be left at the mercy of such human brutes as these" (Jex-Blake, *Medical Women*, 161).

IV. All-Girl Allopaths: Fighting Fire with Femininity in the Doctress Novels

In the popular press, the arguments of feminists and their opponents ranged over the whole field of women's rights, often using the woman doctor as a prime example—or target. While the other professions, such as law or the Anglican ministry, were still closed to women, and suffrage continued to be an elusive goal, medicine was one of the highest and most visible achievements available to the educated, working woman. Consequently, even if writers did not write about the medical woman specifically, she was often referred to in more general discussions about the Woman Question, to the extent that to attack or support one was often to imply one's attitude towards the other. Late nineteenth-century fiction, however, did not make use of the woman doctor figure with quite as much frequency. Writers who wished to incorporate the Woman Question into their narratives had a range of imaginative options at their disposal, and so created a variety of female characters who could play out their creators' views. The New Woman—whether favourably portrayed or not—could as easily be a nurse (*Hilda Wade,* 1900), a typist (*The Odd Women* 1893), or, frequently, an artist or writer (*A Story of a Modern Woman,* 1894; *The Beth Book,* 1894).

By contrast, the woman doctor as a central character occurs in only a handful of novels, all of which are organized around romantic plots. But in spite of being set within a romance environment, these doctress novels all have something to say about the propriety or impropriety of women pursuing higher education and professional careers. Most of the novels adopt a very supportive, propagandistic stance towards the cause of women's rights: building directly on the arguments circulating in the non-fiction press, the novels use the female doctor as a positive example of all that can be achieved by a well-educated, womanly woman. But whether the portrayal of the woman doctor is designed to support or criticize her cause, the explicit manifestations of the debate reflect its natural, essentialist elements. As a result, even when the writers' intentions towards the cause are good, the ultimate effect is to impose limitations on definitions of womanhood, both within the novel, and without, if the text has any power to influence its readers and their culture.

Most of the doctress novels do take up the questions of the propriety of medical work for women, and women's fitness to practise it, but while the reasoning behind the fictional accounts is similar to that employed in the non-fictional arena of debate, the medical woman's cause as advanced through narrative is often constrained to work through less direct means. For example, while it may have been considered acceptable to refer to specific features of female physiology as a defence for women' s work and education in the popular press, such directness was considered inappropriate, even taboo, in fiction. Authors and publishers always had to consider the tastes of their readers, and the expectations of powerful lending libraries like Mudie's, which refused to carry any works that would bring a blush to a young person's cheek if parents or older siblings were careless enough to let said young person share their borrowed volumes. Instead, the natural, biological femininity of the woman doctor is discussed obliquely, if at all; it is more likely to be implied by the portrayal of the characters as attractive, healthy, and pure-minded.

In fact, many of the more positively-portrayed female professionals simply do not succumb to stereotypical weakness and illness; or if they do overextend themselves (during a diphtheria epidemic, for instance) they are able to bounce back as well as their male colleagues might do. Only one woman doctor becomes life-threateningly ill—Anne Elliot's Edith Romney (*Dr. Edith Romney*, 1883)—but she does recover; and the period of enforced reflection brought on by the illness only helps to strengthen her resolve to continue practising medicine, and leads her to see the women's rights movement in general with more sympathy and interest than she had done previously. Not only does Edith emerge from her sickness a stronger person, her brush with death also comes as a wake-up call to her one-time rivals, Fullagher and Fane. True, it takes her position of weakness and dependence to act as a catalyst for engaging their full sympathies (and in Fane's case, love), but the result is that both men end up with new respect for Edith as an independent woman and professional. The means may be questionable to modern feminists—her weakness is a necessary aid to carry the political point—but the ends are satisfactory, as, in true novel form, they bring out the best in characters, and bring them closer together.

The portrayal of Edith's illness as a morally transformative experience follows what Miriam Baylim, in *The Sickroom in Victorian Fiction,* describes as a well-established convention of nineteenth-century novels. But illness for the female practitioner is far more the exception than the rule: the transformative experience for most medical women in the doctress novels comes about through the giving of treatment, rather than the reception of it. And often, it is others around her who emerge from the experience with a changed outlook. Many fictional women doctors prove their intellectual and physical capacities through positive demonstrations, using their healthy, vigorous, minds and bodies to help the sick and injured. In addition to their female instincts to nurture and protect, they demonstrate the decisiveness and power of body and personality that were held to be essential qualities in the male doctor—and which were often held up as being beyond the reach of most women. Thus Drs. Gale, Prince, Keeling, and Langton all exemplify the trained woman's ability to combine the stereotypically masculine capacity for action—curing—with the feminine knack for caring. In fact, these women often run the risks of threatening the masculinity of other male characters, many of whom are portrayed as lacking equal amounts of energy and will, or of alienating the other women they know with their baffling professional expertise.

Charles Reade's Rhoda Gale (*A Woman Hater,* 1877), for example, is initially portrayed as rather small and feminine (like a fox—or a witch). She is nevertheless a powerhouse: firm, decisive, authoritative, even dictatorial. She quickly casts off the role of dependent under Harrington Vizard's patronage, and sets herself up instead as the public health officer for his estate, poking and prying into the cottages of his tenants, and using her scientific and moral expertise to make Vizard live up to his responsibilities to provide clean water and sanitary housing to his tenants:

> " . . . when the mischief is done, and the cottages are built on a hill three miles from water, then all that science can do is to show the remedy, and the remedy is—boring . . . Are your subjects to drink poison, or will you bore me a well? — Oh, please!"
>
> "Do you hear that?" said Vizard, piteously, to Uxmoor. "Threatened and cajoled in one breath. Who can resist this fatal sex?—Miss Gale, I will bore a well on Hillstoke common." (332-333).

The other ladies in Vizard's household find Rhoda "boring," but she has come to address "mature minds," not "children" (332). Rhoda may dress like a lady, and she cannot help taking a lady's dependent tone for a moment when she asks Vizard for the well—nevertheless, this one plea comes in the middle of a lengthy presentation accompanied by diagrams, lab data, and advanced theories of hygiene, delivered in a business-like fashion to the men of business in the room. Unlike the other ladies present, Rhoda does not win favour through jokes, flirtation, pouting, or tears—the standard arsenal employed throughout the rest of the novel by the very conventional Zoe Vizard and Fanny Dover. To these ladies, the very subject of improvements is incomprehensible and tedious—they cannot understand the social, economic, or moral ramifications of Rhoda's findings. But Vizard and his fellow land-owner Uxmoor do: when Rhoda informs them that she has discovered "three generations . . . living together, night and day, in one room [,] [t]his conveyed no very distinct impression to the ladies; but Vizard, for the first time, turned red at the revelation . . . " (334). Rhoda surpasses the men's knowledge of science; she matches them in her knowledge of the complex depths of real life lurking beneath the surface of pretty facades, possessing a degree of experience that the other ladies cannot imagine. When Rhoda makes her recommendations to Vizard, she may "cajole" like a member of the "fatal sex" (333); but what convinces Vizard to act is the knowledge and experience of a fellow man of the world. In Reade's novel, Rhoda's problematic equality with men is mitigated by her exclusion from romantic involvement. Reade is not quite able to find a place for the medical New Woman in his understanding of sexual relations; nevertheless, he does seem serious about defending the doctress' intellectual and experiential qualifications to engage in the male domain of professional relationships.

In what might be an even bolder example, Nan Prince, in *A Country Doctor* (Sarah Orne Jewett, 1884) shocks and confounds her would-be suitor George Gerry, when, after keeping her medical knowledge discreetly suppressed, she steps forward in an emergency to reset a farmer's dislocated shoulder:

> Nan pushed the spectators into the doorway of the kitchen, and quickly stooped and unbuttoned her right boot, and then planted her foot on the damaged shoulder and caught up the hand and gave a quick pull, the secret of which nobody understood; but there was an unpleasant cluck as the bone went back into its socket, and a yell from the sufferer, who scrambled to his feet . . . 'I'll be hanged if she ain't set it,' he said . . . 'You're the smartest young woman I ever see.' (265)

Nan very professionally sets aside useless decorum to act independently, authoritatively, and barefoot, much to her companion's dismay. Gerry has seen his would-be love-interest make what could, in other circumstances, be interpreted as a provocative, sexual gesture, by undressing—at least to the extent of one foot. But Nan is not thinking of sex at all, nor of the potential power and weakness associated with a woman's "unveiling" any part of herself before a man. On the contrary, in this scene Nan has taken the image of a passive female nature unveiling herself before masculine science, and has integrated that opposition into one figure, the woman of science. This imagery, combined with her decisive demonstration of professional knowledge, has left her companion completely at a loss to explain his role in the episode to himself: ". . . the young man did not like to think yet of the noise the returning bone had made. He was stout-hearted enough usually; as brave a fellow as one could wish to see; but he felt weak and womanish, and somehow wished it had been he who could play the doctor" (266).

To a conventionally-minded man like Gerry, the relationship between sexes allows for only one person to claim masculine strengths, with no sharing; when Nan's actions make that claim, unmistakably, it leaves Gerry with nowhere to place himself except in the feminine position. But I would argue that the problems of identity this scene raises for Gerry are not meant by the novel to complicate our understanding of Nan's identity as a medical woman. Afterwards, Gerry persists in his courtship of Nan, as though this unusual episode had not taken place; Nan never takes any notice of it at all: to her, so naturally a doctor, nothing unnatural has occurred. This episode has attempted to win a point for the cause of the medical woman; her actions may seem to infringe on the privileges of masculinity, but this incident, combined with Nan's behaviour in the rest of the novel, means to reassure. There has been nothing conspiratorial, or corrupt in her actions; rather, the instinctive and spiritual nature of her calling to the medical profession elevates her above the tension between genders to a protected, neutral position of pure professionalism.

And such "manly" feats are not reserved, for propriety's sake, only for those doctress heroines who remain celibate in their narratives.[9] Other fictional doctresses perform with similarly "masculine" heroism, while keeping their femininity intact; in these cases, their male love-interests, rather than fleeing in horror from what they perceive to be doctor-viragos, are led to an even greater appreciation of the women's physical and intellectual strength, as expressions of depth and strength of character that they cannot find in other, more conventional women. For example, Georgia Keeling (*Peace with Honour*, Sidney Grier, 1897) is capable not only of fending for herself, but also of risking her life to save her travelling companions, and their trade mission to Ethiopia:

> Do you know that when she was at Bir-ul-Malikat, that wicked old woman Khadija tried to get her to lead you and your men into a trap, on the pretence that by calling to you and beckoning you she would warn you of an ambuscade. An ordinary woman would have yielded to the impulse of the moment—I should have myself—and destroyed you, with the purest desire for your safety; but Georgie had the strength of mind to reason the matter out, all in an instant. She refused to call to you, and you were saved. And it is a woman like that whom you expect to fall down and worship your slightest whim! (396)

Georgia's insistence on both professional and patriotic duty are at first incomprehensible and daunting obstacles to Major Dick North. His experience of women has taught him only one way of responding, through a form of chivalry that condescends as it protects. Worse, his inability to accept Georgia's masculine competence as part of her womanly attractions also makes him unable to fully trust her. Although they deny it, he and the other men in the mission are reluctant to let her treat their leader, Sir Dugald, after he is poisoned. They say, chivalrously, that they are trying to protect her reputation; but their protection masks a lack of confidence and an insistence on her dependence. Georgia perseveres in doing her duty, and her successful participation in the very "masculine" colonial adventure provides her with opportunities to showcase her merits that real medical women, in tamer, less romanticized surroundings might not have. She risks her life to save the mission; but she also risks her life to prove herself—to the other characters in the novel, and to readers. Her "masculine" knowledge, combined with a manly sense of honour, proves her worth. She ceases to be a puzzle, or a threat, to North—and far from unmanning him, or unsexing herself, she sets a standard for duty that pushes them both to heights of noble, patriotic, conduct:

> "No, Dick, go—for honour's sake"—and she repeated mechanically the words which had been burning themselves into her brain during the last half-hour—
>
> 'I could not love thee dear, so much,
> Loved I not honour more.'
>
> "Go dear," she said again, and took his face between her hands and kissed him on the forehead.
>
> "It's women like you that make men heroes in spite of themselves," broke out Dick. (325-26)

Like North, Vivian Lester in *Sweethearts and Friends* (Maxwell Grey, 1897) is only slowly brought round to the feminist reformers' belief that a strong, educated woman with a higher moral purpose is more worthy than a well-bred, but coquettish, young lady—and it takes an unexpected act of heroism for the lesson to finally hit home. Earlier in their relationship, Lester is, if not threatened, then nonplussed by Amy's powers, which seem to render his knightly chivalry inconsequential. He respects her, and regards her with awe, but cannot help but ask, "Could any man love a being so strong, so superior, so capable?" (57). Although impressed by Amy, he prefers the "ideal" woman "whose weakness is her strength, in whom feeling replaces intellect, meekness and refinement power" (15). His relationship to the very "ideal" Lettice, however, teaches him that this perfection of femininity –weakness—results in a creature utterly lacking in moral character, and resistant to all attempts at correction. Lettice is no intellectual, but her expertise in feelings only makes her manipulative, selfish, and deceitful. Continually frustrated and wounded by Lettice, Lester begins to doubt his ideals.

His growing appreciation for the woman who is able to integrate "masculine" strength with femininity is decisively confirmed when Amy single-handedly saves him from a burning building (after he has manfully saved a child from the fire first). Far from being repulsed by her near-superhuman powers, Lester is man enough himself to be grateful for the love of such a brave and competent woman:

> "You must marry me now, dearest " . . .
>
> "But honour and duty come first. I can not give up my calling. As for love—"
>
> "My brave, beautiful prophetess, when I saw your face through the flames—'An angel yet—yet—a woman'"—can we blame our own prudent, perfect knight if his voice failed him here and tears sprang unbidden?—"Amy, I am not the hide-bound, prejudiced ass I was. Love has taught me better; a woman's love, a woman's heroism. Dear, I will never hinder you, only give me the privilege of helping." (249)[10]

As the novel itself suggests, Lester is an incurable idealist (14-15), embodying the dangerous theories of real social observers like Coventry Patmore. But although Lester is a fictional character, his experiences with angels and women prove to be more realistic and disillusioning than those invoked by Patmore's influential rhetoric. Lester has met the "Angel" in Lettice, and found her to be flawed and incomplete; he learns, and the novel asserts, that there can be no ideal Angel unless she is first a woman, made complete by a combination of womanly *and* manly strengths.

No matter how amazing or improbable these demonstrations of the woman doctor's powers may be, their creators make sure that their womanliness remains their greatest power of all. The novels do not disguise the doctresses' competence and power, but it seems to be very much their mission to reassure readers that the woman doctor, whether fictional or otherwise, *contains* these powers in a safe, familiar, feminine form. For example, almost every woman doctor, especially every one who ends up the happy heroine of romance, is portrayed as being attractive, full of health and vigour, and endowed with classically ideal features and masses of hair. The woman doctor, these portrayals assert, is not weakened, depleted, or desiccated by too much study; nor have her medical experiences unsexed her. Dr. Helen Brent (Annie Nathan Meyer, 1892) is only one among many fictional doctor-heroines who are "superbly tall, and the figure of a very Juno"; and the description of her which follows is very much in the convention observed by other writers concerned to portray their doctresses as both competent and gorgeous:

> The expression of her face is peculiarly soft and winning; yet the high forehead, unmarred by either bang or curl, and the rather square jaw, betoken the presence of will and determination. Her orbs are of a lustrous, deep sapphire, and her hair, which was simply caught up in a loose coil, and fastened with a large tortoise-shell pin, is of a rare golden chestnut shade. (18)[11]

Writers like Margaret Todd (*Mona Maclean, Medical Student*, 1896) make a further point of describing their medical heroines as "healthy animals" (89)—a reference to the Spenserian view of health as depending on the individual's observance of their natural strengths and weaknesses. By making Mona Maclean, medical student, a healthy—and attractive—animal, Todd is tacitly demonstrating that Mona has achieved an ideal, natural balance between developing her body and mind for the help of her fellow-animals and preserving her biologically necessary femininity.

Moreover, young doctresses like Mona prove their womanliness beyond the basic animal level. Despite the nature of their work, and their knowledge, so far outside the scope of the pure and naive traditional heroine, these young women doctors have retained all of the ladylike qualities and skills considered to be the hallmark of civilized middle-class womanhood. When they are at home, for instance, they practise their needlework, music or art; Dr. Victoria (G.G. Alexander, 1881) takes breaks from her studies by working on her embroidery; Dr. Edith plays piano while her niece Winnifred sings; Mona is such an accomplished student of fashion, as well as of *materia medica*, that she finds it distressingly easy to take up the role of milliner in her aunt's dismally unstylish small-town shop. Despite the demands of their work—indeed, most often, it is as a reaction to the harsh conditions of medical practice—the women all make it a point to surround themselves with domestic comfort and order when they are not on duty.

The novels provide a reassuring simulation of real-life possibilities, where the doctress' career is shown to be completely compatible with a woman's expected domestic responsibilities. Consequently, and as a pointed refutation of their opponents' worst fears, the fictional woman doctor is as comfortable arranging her dinner menus or her decor, as she is dressing wounds or dissecting specimens. For example, Dr. Edith's drawing room is suitably decorated with lace curtains, a tea service, and piano, and "wanted none of the trifles and nicknacks which are supposed to denote feminine taste and occupancy" (22). Similarly, the comfortable, yet plush decor choices made by Dr. Zay (Elizabeth Stuart Phelps, 1872) reveal a soft, even sensuous side to her personality that Waldo Yorke had suspected might be missing:

> There were flowers, too. The lamps had green and yellow globes. There were many pillows in the room, of odd shapes, and all sorts of hospitable things to sit on; an open fire-place, filled now with ferns: yet nothing seemed to be a reproduction of a fashionable craze . . . One did not even think of Queen Anne or Louis Quinze, but only of Doctor Zay, who had a pleasant room and lived there . . . It affected Yorke strongly to meet his doctor here,—a lady, like other ladies, in a shelter, among little lovely things, quiet and set apart, protected from encroachments, forgetful of care. (157-8)

In this space, Yorke is not dominated by Dr. Zay, the doctor, as a patient; he feels more securely equal in the presence of Dr. Zay-as-hostess. Here, he finds that Dr. Zay can appreciate feeling sheltered and protected—but this aspect of her does not undermine her authority; rather, it makes her more real and accessible to Yorke. She is neither alien, nor divine; in this very ordinary parlour, Yorke discovers the reassuring evidence that he needs to understand Dr. Zay as familiar, normal, and conventional *enough* to be a candidate for heterosexual romance and marriage.

And as further proof of their femininity, and "normal" sexual availability, the womanly young doctresses, like their real-life role-models, make a point of dressing elegantly and neatly, with the greatest of taste, and political sensitivity. None of the doctresses is ever portrayed wearing the suspiciously mannish "rational dress," preferring simple, well-tailored dark clothes for work, and prettier, more luxurious designs for relaxation. Women doctors had to pick their battles, and challenging society's ideas of acceptable feminine appearance and attractiveness was often not one of them. So Helen Brent, for example, appears at the dedication of a new hospital wearing

> a garment of some sort of soft, clinging material of sapphire blue, just the color to bring out her deep eyes (but then we do not dare accuse the learned doctor of possessing any of the weaknesses of her sex); while upon the golden chestnut hair reposed a dainty little bonnet of dark-blue straw, and we will add that its strings were neatly tied, and not hanging in a slovenly stream down her back, as, doubtless, some of those present expected to see them. (19)

Helen's near contemporary, Dr. Zay, dresses more soberly in blue flannel dresses for work, but when she is off duty, much to Yorke's delight, she chooses to wear such things as "a muslin gown of a violet color; it was finished at the throat and wrists by fluttering satin ribbons and lace; it was a cool, sheer thing, as befitted the warm night—a parlor dress, sweeping to the floor" (155).

The only medical woman who actually dares wear a divided skirt is Arabella Kenealy's Dr. Janet of Harley Street (1893): "She was clad in a rough, loosely-fitting tweed garb—one could not call it a gown, for the skirt was of that genus distinguished by the term 'divided,' and the bodice was made and worn after the fashion of a man's shooting coat" (86-87)—but her choice of dress is in keeping with her own self-avowed neuter status. To Dr. Janet, decided femininity is woman's natural state (she defines herself as aberrational), and something to be carefully protected, but it also presents serious obstacles to girls who wish to be taken seriously outside the traditional female sphere:

> Good looks . . . are the greatest of all obstacles to a woman's success. They attract men's attention to her. This takes her attention from her work, and worse still, brings other women down upon her. Yes, believe me, beauty is a very doubtful blessing to our sex, and especially this is true of those members of it who have to get their own living . . . I thank the lucky star which presided over my birth and ruled that I should be plain . . . Pretty women . . . have few friends of either sex. Women discountenance them—some because they are envious, others because they are afraid for husband, son, or brother. Men resent them for being too attractive to approach platonically, and incapable of reciprocating all the unplatonic interest with which they are favoured. (100-101)

Dr. Janet recognizes one of the leading objections to the entrance of women to the medical profession—that male colleagues (and patients) would never be able to escape the fact of female sexuality, as represented here by "good looks." The implication is that men are somehow able to check their sexuality at the door; it is always within their power to use it or not as the situation warrants—and apparently, if men decide the situation warrants "unplatonic interests" that is nothing to reproach themselves with.

By contrast, women are forever doomed to bear the burden, and the responsibility, not only for their sexuality, but for men's as well. Nevertheless, despite the problems that "good looks" cause for the would-be professional woman, it is a problem that must be accepted as natural and inevitable. For Dr. Janet's own female students, she cannot be firm enough on the subject of their dressing with appropriate femininity. Dr. Janet exhibits a conventional, conservative preference for seeing young ladies conform to the natural, biological realities of their gender, by dressing as attractively as possible: "Why bless my soul! Miss Grant, what, in the name of goodness, has come to you that you should shave your pretty head and don a billycock? Gracious! isn't the world ugly enough, but you must spoil the little beauty God has given you with your preposterous shirt-fronts and coat-tails!" (133).

There are occasions when—aside from the requirements of her job—the young medical woman of fiction does step outside the bounds of traditional notions of ladylike behaviour to indulge in more physical activity than may have been thought proper by her critics. Mona Maclean, for example, likes to go on rambling outdoor walks, to botanize, or just to explore; her idea of an ideal summer holiday includes "shooting, and fishing, and sketching, and climbing" (12). Dr. Amy also enjoys a good hike; and Dr. Zay drives her own horse and buggy (though this is less shocking in an American). Noticeably, none of them rides a bicycle, but Helen Brent includes this activity in her prescription to counter the effects of empty socializing and husband-hunting: "Prescription: Loose, sensible, plain gowns. Gymnasium at least twice weekly. Horseback or bicycle tri-weekly for an hour in morning, after light breakfast. Early hours for retiring. Liberty to seek the quiet of her room, if desired. Liberty to seek the companionship of her classmates" (63).[12]

Such activity may not have been that scandalous, though, to many readers, and may even have appealed to then-current ideas of progress and racial health. The heroine who walks has a respectable enough tradition in nineteenth-century fiction; think of Jane Eyre, or many of Austen's heroines. Moreover, among late nineteenth-century supporters of girls' educational reform, physical education and sports were becoming an increasingly acceptable means of emulating the boys' curriculum. Many girls' schools and colleges featured calisthenics in their new gymnasia, and field hockey was making competitiveness and team spirit central features of school life, just as they were for boys.[13] There was also an increasing movement, even among male physicians, to condemn tight-lacing and idleness as contributing to poor health, and poor moral habits like the dreaded self-abuse. Poor physical and moral health would only be passed on to the next, sickly, generation;

exercise for both sexes was increasingly seen as being essential to the improvement of the white, middle-class racial stock. Consequently, even in those novels which demonstrate an ambivalent or negative attitude towards the unconventional medical woman, her physical activity at least is portrayed as being the product of a simple, girlish expression of health and energy, reconfirming the idea that wholesome activity, and exercise of both mind and body, is better for a young woman's femininity than the neurosis-inducing idleness of a life of luxury.

It is this mental and physical wholesomeness—delicacy of mind in a sturdy frame—that protects the young woman's femininity during her medical study and career.[14] The actual subject matter of medical study and practice is often referred to obliquely, and with the utmost caution, to the extent that we do not often see the fictional woman doctor actively engaged in her work on real patients, or cadavers. Here again, the novels show what the non-fiction arguments in favour of women doctors can only tell. For most of the writers of these doctress novels, it all comes down to a matter of emphasis: it is more important to create a positive portrayal of true womanly nature flourishing under circumstances supposedly inimical to it, than it is to detail the actual inimical circumstances. What matters is not the harrowing knowledge the women have acquired, but their ability to handle it, to integrate it into their lives with no disruption to their femininity, or their feminine relationship to men.

For instance, many of the novels are more concerned to portray women doctors already in practice, as more mature women who are well able to manage a career and a romantic relationship, without the interference of any girlish weakness or self-doubt. Few novels deal with the development of the girl into the woman doctor; fewer still provide any concrete details about life as a lady medical student, working side by side with male classmates and professors. In the cases of Drs. Romney, Brent, Keeling, Marsh, Langton, Breen, Zay, Glen, and Borrodaile, their medical school days are the subject of only the most passing references, if that, with perhaps a gracious acknowledgment of male gentlemanliness along the way to generate good will. Even in the cases of those whose student days are more directly addressed, the clinical details are downplayed, in exchange for more involved examinations of the political or philosophical experiences the women undergo.

For example, Rhoda Gale's tale of medical school is inserted—forcibly—into the larger narrative of *The Woman Hater* less to inform the reader about the behind-the-scenes details of the woman student's curriculum, than it is to provide a heavily propagandistic account of the quest for women's medical education in general. Rhoda's story is Sophia Jex-Blake's story in many ways, particularly in its parallels with the struggle in Edinburgh; Reade further handles Rhoda's account so as to provide the maximum opportunity for Rhoda and Vizard to condemn the trades-unionism of the male medical establishment. In fact, as David Finkelstein has noted, Reade was concerned about certain particular details of medical practice, namely the maltreatment, and even rape, of female patients by male doctors; however, his publisher, the illustrious Blackwood, drew the line at that level of specificity. As Finkelstein reports, Blackwood warned Reade that "[t]he above subject carried out fully and forcibly would compromise both you and me and defeat the object you have in view at the first start . . . I would shrink . . . and advise you to shrink from anything like a general accusation of the Doctors as the impairers of female modesty" (qtd. in Finkelstein, 340). Reade persuaded Blackwood that the medical women controversy would be good for sales of an otherwise conventional romance; then, by agreeing to Blackwood's demands for propriety by limiting the amount of medical or physical details, Reade managed to divert (some) attention from the more political aspects of his medical woman argument. In this case, downplaying verisimilitude was a concession Reade was willing to make to his publisher in order to perform the more important work of propaganda.

Nan Prince's experiences as a student are, by contrast, considerably less political than Rhoda's. Rather, the apolitical nature of Nan's decision to become a doctor is part of the larger theme of the novel, which suggests that individuals best serve the Divine plan when they follow their natural inclinations, informed by common sense, and free of the artifice and pretension of the urban, modern world:

> [E]very student of medicine should be fitted by nature with a power of insight, a gift for his business, for knowing what is the right thing to do, and the right time and way to do it; must have this God-given power in his own nature of using and discovering the resources of medicine without constant reliance upon the books or the fashion. (185)

In fact, Nan's formal education at a medical school is glossed over nearly altogether, as secondary to the education she receives as the foster daughter and protégée of Dr. Leslie, the very pattern of the country doctor who is wise enough to work with nature and not against it.

Even the novel that would appear to deal most obviously with life in medical school—*Mona Maclean, Medical Student*—is less to do with Mona's medical education than with teaching her priorities about balancing her many interests, including her career and her love-life. On the one hand, this choice to stay focussed on the woman doctor's personal life serves to instruct readers that despite her extra-ordinary career choice, the medical woman has very ordinary and familiar feelings and ideas. On the other hand, there are some hints that readers and publishers were simply uninterested in what went on behind closed hospital doors. At least one reviewer found that the propagandizing content of the novel was quite enough to take; and that the addition of medical props was an unnecessary touch. *The Athenaeum* offers a "cordial welcome" to *Mona Maclean* as a "clever and interesting story"; it also finds that the novel "is eminently a novel with a purpose, and suffers from the drawbacks inherent in works of the proselytizing stamp. The author is a little too anxious to advertise his familiarity with the pharmacopoeia and the dissecting-room, with the result that the dialogue is in places terribly shoppy . . . " (774). The reviewer makes no objections to Mona's choice of profession; rather, he or she seems to be more concerned with how convincingly Margaret Todd (publishing at this point as "Graham Travers") delineates Mona and the other characters in their assigned roles.[15]

Many of the doctress novels, even those which do not deal directly with the subject of medical education, nevertheless find some way to engage with the problem posed by the lady's contact with the naked, exposed flesh of the cadaver or surgical patient. Supposedly, as we have seen, the true lady could not study or work with such raw examples of human dissolution or frailty without becoming hardened and unsexed. Many of the doctress novels share a commitment to dispelling that misconception and creating a positive conception of this aspect of medical work and study in the readers' minds instead.

For example, when Phyllis begins her studies under Dr. Janet's tutelage, her classmates despair of her ever becoming a good doctor, because she seems too susceptible to emotion in the presence of both patients and laboratory specimens. But Dr. Janet is encouraged by Phyllis' reactions, recognizing that her displays of emotion are not signs of weakness, intimidation, or disgust; rather, that Phyllis is moved with awe for the miraculous complexity of the human body proves that she has retained a womanly sensitivity and empathy that is sometimes lacking in male doctors and those who would emulate them:

> "She will never make a doctor," some of [Phyllis'] companions said to Dr. Janet; "she will never learn to think as men do and be essentially scientific."
>
> "She will never forget that human nature is not comprised by anatomy, physiology and chemistry," the latter answered sharply, "and I do not wish her to think as men think, else what is the use of nature having specialised her faculties? The very reason nature makes us different, is that we may bring to bear upon her problems totally different processes and modes of thought." (133)

To Phyllis, the body—even the cadaver, or its several parts—is evidence of a higher power, and a reminder of the spiritual aspect of life that accompanies the limited physical experience:

> Her cheeks flushed with shameful crimson, and the tears came when, in the course of study, she learnt from the critical, cold lips of science, that the human eye is but a 'very poor optical instrument' . . . Was the eye nothing more than this— . . . this marvellous, dear, beautiful thing, we, in our infinite littleness, have put on our glasses to inspect, and have with frigid arrogance dismissed as being but a poor attempt on the part of our Creator! . . . Phyllis dropped her lids upon the blasphemy, and burnt the page it blackened. (132-33)

When her studies bring her into contact with a range of living patients, most of whom belong to the lower classes, she experiences compassion for the suffering and pain she sees others experiencing, and indignation that so much of the distress she sees in her patients could be avoided through education and activism. The emotions she feels may be stereotypically feminine, but her reaction to them is not: rather than shrinking from her work in horror and revulsion, she becomes ever more absorbed in helping where she can. "Weakness"—the capacity to feel strong emotions—is shown to be a subjective assessment of a woman's character: that she feels is womanly, but that she acts with knowledge and compassion as a result is more womanly still. This was an important point in the argument for the *need* for women doctors. At a time when medicine was becoming dominated by the scientific method, with its emphasis on objectivity and clinical distance, the supporters of medical women emphasized the beneficial effects of a female presence in the profession. Women, presumed to be naturally skilled in caring, would emphasize prevention and public health initiatives, aspects of medicine which tended to be overlooked by the mainstream clinical and research practices. The doctress, with her instinctive preference for contact, rather than removal, could operate within the profession as a means of complementing—or compensating for –the sometimes dehumanizing "masculine" science with feminine compassion, morality, and spirituality.

While some novels use experiences like Phyllis' to show that medical work is not unsexing, but ennobling, others try to show that it is not unsexing, or ennobling—it is just work, and nothing for anyone—male or female—to be afraid of, or corrupted by. Mona, for example, makes no claim to be as spiritually moved by anatomy as Phyllis is. When her friends question her about her studies, Mona replies frankly that working with cadavers is ghastly, and difficult to take—but she and her female classmates find that the work can be endured when placed within its larger context:

> Before one really gets into the work it is worse than ghastly, it is awful. That is why I say that outsiders should never see it. For the first few days, I used to clench my teeth, and repeat to myself over and over again, 'After life's fitful fever, he sleeps well.' It sounds ironical, does not it? But it comforted me. On any theory of life, this struggle was over for one poor soul; and, judging by the net result in this world, it must have been a sore and bitter struggle. But you know I could not have gone on like that; it would have killed me. I had to cease thinking about it at all in that way, and look upon it simply as my daily work—sometimes commonplace, sometimes enthralling. Sir Douglas would say I grew hardened, but I don't think I did. (174)

It is exactly this sort of level-headed attitude that convinced many critics of women's medical education that the work was indeed unsexing: a lady's refinement was seen to be fundamentally incompatible with such gross work, made even more unacceptable by the manual nature of it. And yet, the novel in this case tries to dispel such prejudices with proof to the contrary: Mona is apparently an expert anatomist, and yet she is also healthy and feminine, with a reassuringly girlish love of outdoor rambles, champagne, and fresh bonnet ribbons. It is not that Mona is unaffected by the nature of her work; but rather, as a pure-minded and womanly woman, she is able to view the work with perspective, as one form of knowledge among many. With such a positive, respectful attitude, knowledge can only be improving, never coarsening or unsexing. Mona's wholesome example eventually conquers the misgivings of all who fear for her womanliness. Both Dudley and Sir Douglas learn that the only coarseness to be found among such women as Mona lies with those who are not sufficiently respectful of the dedicated woman doctor's pure motives:

> "I think [said Dudley] the fundamental mistake of our civilisation has been educating women as if they were all run in one mould. She will get her eyes opened, of course, if she studies medicine, but some women never attain the possibilities of their nature in the shadow of the convent walls. Frankly, I have no great fancy for artificially reared purity."
>
> "Artificially reared!" exclaimed [Sir Douglas]. "My dear sir, there are a few intermediate stages between the hothouse and the dunghill. If it were only art, or literature, or politics, or even science, but anatomy—the dissecting room!"
>
> "Well," said Dudley . . . "even anatomy, like most things, is as you make it. Many men take possession of a 'little city of sewers,' but I should think a pure and good woman might chance to find herself in the 'temple of the Holy Ghost.'" (264)

Dudley here seems to be indirectly espousing a progressive ideal of education which is more morally and physically healthy for England's men and women than the declining model of foreign, conventual immurement. For the fictional woman doctor, he argues—and by extension, for any individual—educational experience of all kinds, including anatomy and dissection, are shown to be impure only as a result of impure thoughts. And impure thoughts are more likely to come as a result of artificially imposed repression and ignorance rather than of scientifically- and spiritually-guided inquiry.

Echoing the arguments made by Jex-Blake and other pro-medical woman supporters, the novels assert that, for the medical student—male or female—committed both to science and to faith, the cadaver is a source of wisdom, whereby knowledge of Nature and appreciation for Divine creativity are gained.

But if these novels offer a defence against the charges that medical practice must be unsexing, the most compelling proof of the female doctor's womanliness is her willingness to undergo the trials of a clinical education in order to help other people. In true, idealized fashion, the lady doctor sacrifices her own comfort and complacency, to acquire the abilities that will enable her to bring particular comfort to women patients. The novels tread carefully around the exact nature of women's special medical needs, but it is clear that the greatest threat to female purity and modesty in medical practice comes from male attendance upon obstetrical or gynecological cases.

Most male doctors in these novels are portrayed as possessing admirable amounts of compassion, and these fictional physicians never commit the ethical and criminal actions that some of their real-life counterparts were accused of (sexual assault, for example). Nevertheless, even when the fictional male doctor offers efficient and respectful care to his female patients, the woman doctor can go beyond this, because she is truly able to put herself in her female patients' place. She knows that one day she may also suffer through gynecological illness or childbirth, or, like Ethel Borrodaile Weston in *New Grooves* (Annie Thomas, 1871), she has already gone through such ordeals herself: "And then on her couch of pain she made the resolution solemnly to devote herself, should her life be spared, to the task of sparing other women this more than mortal anguish" (115). In this regard, the novels are building directly on one of the central arguments used by real medical women to justify their existence. Feminists and their opponents could argue endlessly about woman's fitness for the work, but if a woman doctor, as well trained as the average male practitioner, could bring care and education to female patients who would otherwise shun the clinic or hospital out of embarrassment, then surely the lives saved were worth the stress of social change.

In general, the novels make this point in episodes that highlight the emotional and moral dimensions of the issue, rather than the medical ones; there are no graphically detailed descriptions of childbirth, or the treatment of internal female ailments. For example, one of Edith Romney's few friends and supporters, Mrs. Stanforth, suffers from some sort of incurable disease—quite possibly cancer—but the details are less important than the fact that Mrs. Stanforth derives great comfort from having Edith—a lady—as both her physician, and her confidante. Edith is unable to save her: there is a suggestion that one reason for Mrs. Stanforth's death is that she did not seek help earlier because she could not bear to consult a man, especially one known for his woman-hating, like Dr. Fullagher. Instead of offering her empathy, and psychological as well as physical comfort, Fullagher deliberately and selfishly teases her:

> He had a special dislike to the fine-lady type of woman, and he had perversely shown himself at his worst during his attendance upon her; and the sensitive, nervous lady, detecting his dryness of manner and lack of sympathy, shrank from him as being what she shudderingly and conclusively said, 'not a gentleman.' The doctor was shrewd enough to divine this judgment on her part, and revenged himself in characteristic fashion by delicately aiding her belief in it. (I, 65)

If Edith delivers specific medical treatment to Mrs. Stanforth, it is not described. Instead, what the novel emphasizes is the companionship Edith is able to offer as a lady, like her patient.

Similarly, Elizabeth Glenn, MB (Annie Swan, 1895 and 1897) derives much of her business from female clients, but beyond mentions of babies being born, the details of her cases are confined to the patients' sick-room confessions. Elizabeth learns about a wide range of female experience in her practice, but the unifying theme of her observations is that women often suffer as much from troubled relationships with their husbands, as they do from more physical complaints. Consequently, Elizabeth often takes it upon herself to intervene in domestic situations where she can, using her female patients' pathetic vulnerability as a wake-up call to their often negligent or thoughtless mates.

Both Dr. Zay and Mona Maclean also go beyond the care of their patients' bodies to care for their relationships, exhibiting an attitude towards medicine that is thus more holistic, or wellness-oriented, than conventionally allopathic. Dr. Zay, for example, steps in with zeal and protectiveness on behalf of an unwed mother. In this case, Dr. Zay convinces the girl to confide the father's name; when Dr. Zay soon after has the chance to heroically save the man's life after a drowning accident, she takes advantage of his gratitude to pressure him into doing what she believes to be the right thing by marrying the girl on the spot. For these medical women, objectivity or clinical distance has no place in their dedication to care for the whole patient. In fact, it is this very willingness to get involved, to bring moral force and motherly care—or coercion—to bear in the sickroom that became a point of pride for many in the medical woman movement.

Mona also becomes involved in the care of an unwed mother, this time as an assistant to Dr. Dudley. Mona has not even admitted her own medical training to Dudley at this point in the narrative, and so is content to play nurse—but she is then moved by compassion and sympathy to take on the more assertive role of patient advocate. When the woman's own mother has nothing but hard words for her fallen daughter, Mona takes her to task for her lack of Christian forgiveness. Mona's involvement in this case has been far removed from the textbook definition of a physician's duties, and yet this experience plays a crucial role in re-kindling her enthusiasm for and dedication to medicine. She has been forcefully reminded that her pursuit of a medical degree is based not on an intellectual duty to cold science, but on a spiritual obligation to serve and comfort:

> More and more heavily the burden of the sorrows of her sex pressed on Mona's heart as the night went on; more and more she longed to carry all

> suffering women in her arms; more and more she felt her unworthiness for the life-work she had chosen, till at last, half unconsciously, she fell on her knees and her thoughts took the form of a prayer . . . now the cold hard lines of duty were broken through by the growing developing force of a living inspiration. We need many fresh initiations into a life-work that is really to move mankind, and Mona underwent one that night at Barntoun Wood, hundreds of miles away from the scene of her studies, with the silvered pines for a temple, the lonely house for a holy place, and a shrine of sin and sorrow. (332-33)

Mona recognizes the special "burden of the sorrows of her sex"; women, quite simply, encounter medical problems that men do not share. And because those medical problems are tightly bound up with social conventions regarding female sexuality, and the need to keep it hidden by a doctrine of modesty, the relationship between a male doctor and a female patient is necessarily complicated. Male doctors are a reminder of male sexuality—and, all too often, the power of men to control women's sexuality, especially in the case of rape or unwanted pregnancy. The medical woman, by contrast, is not a reminder of women's burden, but one who shares in bearing it. Her presence need not be alien, or adversarial; the medical woman can bring with her the sacred, maternal powers afforded to her by church doctrine, as well as the healing powers of medical science.

While the cause of the fictional woman doctor is advanced primarily through examples such as those above, it is not exclusively so. Arguments for the "awful necessity" of women doctors to treat and comfort women patients are always introduced with restraint, but there are frequent instances where the issue of women's intellectual fitness and strength of character moves from the tacit to the unmistakably overt. It seems that political opinion is an accepted topic of polite fiction when real, scientific details about human bodies are not. Thus, the women doctors exemplify in their practices what they often preach in undisguised propaganda. However, while the novels are designed to portray these medical women as both rational and well-spoken, they also take steps to ensure that the women remain naturally and properly feminine. As one of Charles Reade's editors suggested, "The object would be better gained by making the lady act and speak so as to gain the respect of the readers, not by making her scold, and abuse people who though they may be in the wrong are entitled to some consideration at least and of whom the world in general are friends" (qtd. in Finkelstein, 343). Although the point was somewhat lost on Charles Reade, many of the other authors of the doctress novels seemed to have been acting on similar advice. So that if one sure sign of becoming unsexed by work and study was believed to be outspokenness, then these novels exercise a rhetorical strategy which demonstrates, again, that the public has nothing to fear from women doctors.

In fact, while the fictional medical woman has some well-chosen words on the subject of her chosen profession, the narrative is often manipulated so that others can step in to speak for her while she maintains a ladylike silence. Thus, lest the reader be impervious to the woman doctor's self-interested arguments, her case is made to seem even more convincing and reasonable by its support from a variety of respectable quarters, none of whom can be accused of belonging to Eliza Lynn Linton's "shrieking sisterhood."

For example, as mentioned earlier, Rhoda Gale's partisan view of the battle for female medical education is placed firmly, if somewhat inexplicably, in the spotlight in *The Woman Hater*. Vizard—and the narrator—allow her to expound for a good fifty pages on the history of the movement and the claims of the women involved, in the process winning support from both. But while Rhoda is given much opportunity to set forth her case, she is not authorized to proceed without Vizard's request of her, and the narrator's disclaimer:

> She is now going into a controverted matter; and though she is sincere and truthful, she is of necessity a *partisan*. Do not take her for a judge. You be the judge . . . But as a judge never shuts his mind to either side, do not refuse her a fair hearing. Above all, do not underrate the question. Let not

> the balance of your understanding be . . . upset by ephemeral childishness . . . . (193-94).

Rhoda's discourse is filtered through Vizard, who makes encouraging responses along the way both to her and, as internal thoughts, to the reader. Vizard and the narrator work together to frame and interpret Rhoda's remarks. Her account does not come to the reader directly and unexamined; we are reminded throughout that it has the endorsement of both Vizard, a wealthy and powerful man, and the self-appointed omniscient narrator. Furthermore, it is the (male) narrator, not Rhoda, who makes the most lengthy and vehement speeches on behalf of the medical woman's cause :

> It does not matter one straw to *mankind* whether any one woman is called queen, or empress, of India; and it matters greatly to *mankind* whether the whole race of women are to be allowed to study medicine, and practise it, if they can rival the male, or are to be debarred from testing their scientific ability, and so outlawed, *though taxed*, in defiance of British liberty, and all justice human and divine, by eleven hundred lawgivers—most of them fools. (194)

And it is the narrator, not Rhoda, who makes sure the issue is not forgotten. After the novel's characters are accounted for at the end of the story, the narrator segues into a concluding exhortation to the readers to put justice ahead of prejudice: "I hope then, that a few of my influential readers will be vigilant, and challenge a full discussion by the whole mind of Parliament, so that no temporary, pettifogging half-measure may slip into a thin house . . . and so obstruct for many years legislation upon durable principle" (528). The narrator here is referring to the Enabling Bill of 1876, which enabled the medical societies to admit women to examinations. And at a point when women still did not have the vote, Reade's narrator is addressing himself as a man to the *male* readers who could actually affect the prohibitive laws of the time.

Other novels seek to incorporate discussions of the issue with less obvious tactics and less overt appeals to the readers; usually, the subject arises in conversations with friends or potential love-interests. The woman doctor is led to explain her choice of career, sometimes in response to curiosity, often in response to incomprehension, bordering on hostility. The medical woman's arguments are always fair—she argues but does not "scold"; but what reinforces and validates the novel's positive attitude towards her opinions and behaviour are the reactions of her interlocutors. Mona, for example, is barraged with questions by her uncle and aunt, Sir Douglas and Lady Munro; Mona answers them with frankness, trying to convey honestly to them her sense of grave wonder for medical knowledge, side by side with her completely unexceptional girlishness. Her tactics work, as much a result of her attitude and demeanour as of anything she says:

> How could she explain to this man the wonder and the beauty of the work that he dismissed in a brutal phrase? . . . 'To be a true anatomist,' she thought with glowing face, 'one would need to be a mechanician and a scientist, an artist and a philosopher. He who is not something of all these must be content to learn his work as a trade.'
>
> Sir Douglas was looking at her intently. As a medical student she had got beyond his range. As a woman, for the moment, she was beautiful. Such a light is only seen in the eyes of those who can see the ideal in the actual. (22-23)

In response to his interview with Mona, the very traditional and irreproachable Sir Douglas begins to revise his opinions about the incompatibilities of medicine and delicacy. And his sense of reassurance becomes, by extension, a reassurance to the readers. Our contact with the medical woman and her world through such respectable intermediary characters allows us to learn from Mona's example that the medical woman is no rare and disturbing specimen, but just an ordinary, unthreatening girl who balances an expensive taste for the theatre with an impressive devotion to a higher calling.

Often the case of the medical woman is made most strongly when she is not even in the room. Her cause is just enough that she is not left to be its sole defender; others are ready to come to her defence in her absence. To modern readers, there is something disturbing in the way these novels silently relinquish the doctress' control over the discussion of her rights to work and study. The explanation—though not a defence—for this strategy is that the authors apparently believe that only good could come for the medical women through the endorsement of other influential, male, characters, and through the avoidance of an excess of "strong-minded" rhetoric on the part of the women themselves.

For example, in the case of Dr. Victoria, the would-be woman doctor hardly says two words about the subject of her medical education, until it is practically completed. Victoria disappears between the acts, between the end of her nursing career and the start of her medical studies. It is up to her foster-father, Dr. Pringle, to step in during a scene obviously inserted for just this purpose, to champion her against those who would impugn her abilities, and her right to exercise them, behind her back. In his conversation with Nurse Wainscott—a scene which serves no other function than to introduce the debate over the practice of medicine by women—he dismisses all the usual arguments against women doctors, and concludes by wondering

> . . . why a young girl, anxious to do good in her generation—who has mastered all the mystery of nursing, and overcome all the horror with which, until we are familiarised with it, the sight of much that the surgeon has to do produces—is to be doomed to stand by everlastingly with a basin and sponge, when she may feel that she has something more in her, and when she is half inclined to say to some bungling operator—for there are bunglers in all professions—'Come, hold this, and let me take your place. I could do it in half the time, and twice as well myself'. (*Dr. Victoria*, 141-2)

Nurse Wainscott is not entirely convinced, but her conversion is less important than the opportunity her presence has offered Dr. Pringle, a wise and respected man in the novel, to provide the readers with some compelling arguments from a reputable source. When next we see Victoria, her medical education is nearly complete, and she has only to show by example, more than rhetoric, the truth of Dr. Pringle's case for her defence.

In a similar vein, the careers of both Mona and Nan get dissected while the women doctors themselves are nowhere in evidence. Dr. Dudley and Sir Douglas weigh the need for medical women against the possible cost to their femininity, and even though Dudley is quite unaware that Mona is the subject of Sir Douglas' conversation, he is obligated to support her cause against her more conservative uncle's unfounded concerns:

> "Tell me," said [Sir Douglas] eagerly, running his eye from Dudley's cultured face to his long nervous hands, "you ought to know—given a woman, pure, and good, and strong, could she go through it all [medical school] unharmed?"
>
> "Pure, and good, and strong," repeated Dudley reflectively. "Given a woman like that, you may safely send her through hell itself." (*Mona Maclean*, 263-4)

Mona thus receives valuable approbation from experienced men of the world, who are in turn able to prove their own manliness—in Dudley's case, his fitness to be Mona's future husband—by being able to rise above narrow prejudice. Similarly, Nan's education becomes the subject of after-dinner chat between her foster father, Dr. Leslie, and a visiting friend, a character who plays no other role than as a sounding-board for Dr. Leslie's views. Again, the conversation touches on the need for good women doctors—and also moves on to include the need for good, common-sensical, spiritually-motivated doctors in general. Nan's choice of career, in this conversation, as throughout the whole novel, is elevated above superficial concerns about propriety, to become an issue of doing the work one has been divinely called to do, to the best of one's ability. And once again, the woman's career is approved by older, wiser men who have learned to appreciate the workings of both God and Nature: "Do push your little girl ahead if she has the real fitness.

I suppose it is a part of your endowment that you can distinguish the capacities and tendencies of health as well as illness; and there's one thing certain, the world cannot afford to do without the workmen who are masters of their business by divine right" (*A Country Doctor*, 111).

As the above examples demonstrate, the majority of novels which take the woman doctor as their principal subject share a common rhetorical strategy for promoting the cause of women's medical education and practice. That is, rather than pursuing a course of radical defiance, where the woman doctor is made to flourish by virtue of her non-compliance with accepted ideals about femininity and womanly behaviour, the doctress novels prefer a policy of compliance and assimilation. The woman doctor's unconventional choices about education and work are not presented as exciting—or frightening—alternatives to the status quo of gender relations, but are instead made to seem reassuringly natural, as refinements on prevailing ideals about womanhood. Few of the novels deny that the medical woman works, for money, in an otherwise male, and public domain; but at the same time, these works also diligently downplay the potentially sordid nature of this work. Moreover, the novels also emphasize the woman doctor's ability to preserve, even enhance, her femininity on the one hand, while making her the subject of approval by unimpeachably respectable middle- or upper-class characters on the other. As a result, the medical woman's choice of career is shown to be one which actually maintains and promotes the reassuring barriers between genders which played such an essential rôle in the Victorian middle class's ordering of social relations—not simply between the sexes, but, as we will see in later chapters, between the classes and races as well.

And yet, while the doctress novels seem to have been making this strategic effort to address the anxieties of potential critics, and the hesitancy of potential sympathizers, the success of this effort was compromised before it even began by its very nature. By always implicitly working to construct the doctress characters in positive relation to prevailing notions about the nature of femininity and womanliness, the novels are also implicitly working to uphold such notions as the central and uncontested basis of any definition of female identity. The authors of the novels may be trying to suggest that women doctors are capable of being both professional and womanly; but they are also, perhaps inadvertently, agreeing with critics of women's work and education that womanliness—as an essentialized, somehow immutable quality—is the central issue of debate. I would hardly expect this group of authors to do otherwise; their portrayal of fictional women doctors shows a recognition of real women's multiple allegiances, not only to feminist or professional interests, but to interests of class as well—and womanliness is very much an issue of class.

After reading the doctress novels it seems clear that their aim, in most cases, is not revolution, but reform, in the twin beliefs that it is possible to change the role of women in society without fundamentally changing society itself; and that success is more likely to come about through modest and less obtrusive demands than through outright revolt. In real life, many medical women did find that a lady-like measure of compromise brought about great improvements. But as many historians of the nineteenth-century medical women's movement have pointed out, although this strategy in medicine and other fields of feminist endeavour was effective in the short term, it proved itself to be somewhat self-defeating in the long-term. Constant concessions to the demands of womanliness allowed male professionals to severely contain the incursion of women into their ranks, and even more severely limit women's access to the positions of influence and status necessary for maintaining a secure foothold in all but the least prestigious areas of medical practice. Moreover, as I will explain in the next chapter, the experiences of many fictional women doctors seemed to demonstrate—as was the case with their real-life counterparts—that compromise had to be a two-way street. It was one thing for female medical protagonists to reform themselves, but as long as they limited their efforts to that relatively narrow field, there could be no easy way to smooth relations with their economic and emotional antagonists: men.

Chapter Two:
Rivalry and Romance: Medical Women and Their Relationships with Men

In their use of fiction to explore the conditions of possibility surrounding the advent of the female medical professional, the doctress novels prefer a strategy of conciliation, compromise, and assimilation. As I explained in Chapter One, the novels do not—for the most part, cannot—confront directly the anxieties that society felt about women doctors' challenge to the once reassuring boundaries organizing social behaviour. What they can do is emphasize the unobjectionable womanliness of the medical woman. And, as I explain in this chapter, this approach contributes to the doctress novels' distillation of an underlying concern to maintain social divisions into the comforting, familiar structure of the romance, or marriage, plot. But despite this strategy's aim to reduce the controversy surrounding the female medical professional, a degree of tension emerges nevertheless, reminding readers that in fiction, as in real life, the process of social change is easier said than done.

A fictional female doctor's womanliness might be all very acceptable as long as she is only a character sketch, portrayed in isolation; but once her role is set into motion in relation to other characters in the romance plot, her personal and career decisions begin to affect not just her, but everyone around her as well. Like a pebble dropped in once-still water, the social change that is centred in the woman doctor ripples outward to impose social change on others, whether or not they are prepared for it. It becomes clear that most fictional woman doctors are not typical romantic heroines, defined only by their romantic relationship with men, "the object[s] of male attention or rescue" (DuPlessis, 200n22). Rather, they more closely resemble DuPlessis' "female heroes," "central character[s] whose activities, growth, and insight are given much narrative attention and much authorial interest" (200n22). Thus, while the romance plot emphasizes the medical women's emotions, these protagonists also come to be defined by their political and economic involvements as well. As a result, the medical woman's womanliness is not sufficient to protect her from conflicts which encompass, but also go beyond, romance: conflicts with her own sense of loyalty to class, gender, race, and profession; with other women who do not share her desire for education, work and/or social equality; and, especially, with men, who are baffled by the alien combination of romantic love interest with social and economic competitor.

In some of the doctress novels (for example, *Dr. Hermione, Dr. Breen's Practice*), these conflicts can prove overwhelming. Contradictions arise, and the cause of the woman doctor tends to collapse under their weight, dragged under by the demands of a middle-class social order expressed in fiction through the traditional marriage plot. The woman doctor, these novels seem to say, is only a romantic heroine after all. Conflict also gives rise to contradictions in most of the other doctress novels, but in these cases, the result is an attempt at change and social innovation, rather than a surrender to convention. In this group of doctress novels, the strategy is familiar. The woman doctor is presented as being as womanly and unthreatening as possible in both her personal and professional relationships; nevertheless, the novels insist on maintaining the medical woman's professional and economic autonomy throughout, no matter what direction her relationships take. The simple matter of holding onto their careers causes uncharacteristically complex and indeterminate endings for the novels as the female protagonists negotiate not just romantically, but economically and politically, with their male suitors.

Those novels with the strongest propagandistic purpose teach that the medical woman can manage these negotiations satisfactorily. However, what the characters, and their readers, *also* learn is that no matter how strongly the medical woman might wish to avoid disturbing others, there is, in the end, no way to safely contain the consequences of her career choices within the sphere of personal decision-making. The individual actions of a few isolated women doctors cannot bring even personal satisfaction, let alone success, for the whole women's movement, unless the personal becomes political and collective, transforming both women and men. Few doctress novels are explicitly polemical about this point, but they all share a similar message, implied if not stated outright. There can be no happy endings for the woman professional without significant changes in expectations about gender relations—not just in terms of what constitutes womanliness, but in terms of what constitutes manliness as well.

I. Essentialism and Economics: The Implications of Women's Entry Into the Professions

As I discussed in Chapter One, the arguments against middle-class women's work and professionalization were often motivated less by science than by irrational, increasingly obsolete notions about ladylike behaviour, which were in turn based on less explicitly stated concerns about class and status. But while feminists and proponents of women's medical education tended to share their opponents' nearsightedness when it came to arguments based on essentialism, they were nevertheless frequently much more sensitive to the class-based anxieties underlying many of the objections that were levelled against them. Feminists seemed to understand better than their critics that the middle-class stability they supposedly menaced was based not just on social interactions, but on economic ones as well. For this reason, the problems posed by economic competition between men and women are often a key source of conflict in the lives of medical women; thus, a detailed explanation of the causes and consequences of this problematic relationship is a necessary step in understanding the doctress novels.

The economic competition of women with men was seen as a major threat for two reasons. On the one hand, and as I will explain further on in this chapter, professional men were genuinely concerned about the possibility of losing profits to female colleagues; although most medical men did not like to admit it, they shared the protectionist and exclusionary attitudes of working-class union men. On the other hand, there was a more complex basis to the threat posed by women professionals, insofar as their existence had the potential to blur class lines and so undermine the claims to social dominance made by the middle class, especially middle-class men.

As I explained in Chapter One, within the separate spheres doctrine created by the industrial age's capitalist division of labour along gender lines, the ideal woman—the lady—was regarded as the embodiment of middle-class values. Her sheltered life of purity and innocence, free from the demands of competition and the profit motive, was what enabled her to offer rest and respite for her husband, and to act as a moral exemplar for her children and household:

> [this] image of an arena of "freedom" for women was, in turn, central to the representation of domesticity as desirable, and this representation, along with the disincentive to work outside the home that it enforced, was instrumental to the image of women as moral and not economic agents, antidotes to the evils of competition, not competitors themselves. (Poovey, 144)

Success in the marketplace—like success in the jungle—was seen to come only as a result of aggression, violence, and self-interest. By contrast, the domestic environment was the haven, the safe repository of humanity and civilization, represented by decorum, sentiment and self-control (Burstyn, 30).

That a middle-class man had such a home to work for and protect was what made the difference between him and the working classes. The inability of the working class to maintain similar homes—their own private corners of British civilization, filled with gentle, refined, creatures—was evidence of their ineligibility to share in power and influence over their culture. And the symbol of that evidence was often the working-class woman: with her dirty house, dirty children, and dirty person, she was held up as all that was unwomanly, and un-ladylike. Never mind the social conditions that trapped such women and their families in ungenteel poverty; their unpleasant existence proved the superiority of those inhabiting the opposing terms of the relationship. If working was associated with the lower class, then not working, and living in comfort, was the sign of the privileged, upper classes. The middle-class was the progressive, evolutionary contrast to the two. Work was necessary, but the moral ideal of Industry made middle-class labour more respectable than the desperate scrabblings of the poor, or the perceived dilettantism of the rich. The work of middle-class men in public was further valorized by what it could buy in private: a show of leisure and conspicuous consumption that imitated upper-class privilege, but which avoided that group's decadent tendencies through the addition of moral rectitude. So that while the middle-class man was out in the world, working to distinguish himself and his class from those less powerful, or less responsible, and so less deserving, *someone* had to be there, in the middle-class home, to maintain its civilizing influence.

Ladies were seen to be evolutionarily suited for such a role, by virtue of their natural modesty, reticence, empathy, and purity. These superior qualities were, paradoxically, the product of a fragile body and mind, and so could only be successfully fostered in a sheltered, dependent environment. For ladies to go outside the home to study, to work, and to compete in the jungle/ marketplace— as their lower class counterparts were forced to do every day—was to leave the position of moral guardian empty, defying the logic that only ladies could fill it.

Such a change in the so-called natural order of things threatened to undermine all of the gender and class barriers that made women *ladies,* and, more importantly, that made men *men*—middle-class and socially powerful (Poovey, 79). For middle-class women to take on economic equality with men would be to become masculine; coarsened like men—or like lower class women—they would then offer men no incentive to overcome their own coarseness. But more disturbingly, if women left the private sphere to work in the public world, the primary distinction between them and working class women would be gone, thus taking a key distinction between the middle and lower classes—and all the social status and privileges attendant on such a distinction—along with it (Armstrong and Tennenhouse, 118-120). To many social observers, male and female, this was an intolerable proposition:

> . . . men dreaded any change in their sex roles because, as the century drew to a close, they were finding it more and more difficult to "be a man." The masculine role was becoming increasingly uncertain as the work role of men

> grew more "feminine" in its characteristics. Many men, and women too, felt threatened by the reforms prompted by the women's rights movement. (Walsh, 140)

To others, however, it was equally intolerable to impose limitations on women based on the damage that they might do, when their own stated aims about what they were doing tended to reinforce, rather than undermine, familiar social relationships. So despite the critics' objections, women continued to pursue medicine as a profession, motivated by a strong sense of moral and political purpose. At the same time, most pioneer medical women also hoped for economic success, not simply for its own sake, but because in a male-dominated, and increasingly market-driven system, profit for female professionals was one sure sign of public acceptance :

> Now we all agree that pecuniary success is a very convincing thing! We may deplore the low state of society, which will measure truth by dollars; but nevertheless we cannot shut our eyes to the fact, that the mass of mankind do judge by a low standard. To say, such and such a woman is making $2000 a year by the practice of medicine, creates more respect for the work in the minds of most people, than any amount of argument, or abstract statement of the truth and value of the idea, would do. (Blackwell, *Address*, 7)

Feminists knew that the opportunities for financial independence were essential for women's social independence; and the proven ability of educated, skilled women to attract clients, serve them satisfactorily, and be well paid for it, was a powerful justification of feminist arguments for access to the professions. However, the pursuit of this moral, political, and economic mission brought women into direct competition with their male colleagues. And this, I think, is why the professions—the medical profession in particular—resisted women with such stubbornness and hostility. Aside from the social taboos women were breaking by leaving their appointed domestic sphere to take on men's work in the public sphere, the fact was that every woman who made a professional career for herself was potentially doing so by taking work away from a man.

In medicine, especially, women chose a bad time to attempt to be admitted. Not only was the medical profession of the late nineteenth century made up of ordinary men who shared the period's ordinary, but discriminatory, views of women; the profession itself was still undergoing the process of consolidating itself as a professional monopoly in the society, and so was at a point where it was extremely sensitive to any threats to its rising social and economic status. According to Jeffrey Lionel Berlant, in his detailed study of the British medical profession, "monopolization requires domination over the market in order to exclude competitors" (49); a group (including both professions and trades) accomplishes this by restricting outsiders, or by including insiders through a particular system of prerequisites and characteristics (48). The initial motivation for monopolization is to secure economic resources—profit—but once that goal has been secured, the focus shifts towards maintaining or increasing the status and prestige of the group, at which point ideals often become secondary to image (49).

The image the male medical profession craved to project was one which would leave behind the taint of the tradesman or manual labourer, investing its members instead with both the refinement of the gentleman, and the growing authority of the scientist, combined into a unified, homogeneous, elite. But it was just as the male profession was working to consolidate this image that the numbers of women in medicine began to reach levels significant enough to give them an inevitable, but potentially divisive stake, in the professional monopoly of medicine.

As Berlant describes it, the process of monopoly formation develops through several steps, most of which involve the manipulation of public relations, although that may or may not happen through a deliberate campaign. The first step involves creating a unique commodity to monopolize. In the case of the medical profession, this meant convincing the public that it was not a trade—the source of manually produced goods or services—but the provider of a special, knowledge-based service that was commodified by attaching a fee to it. Next, the group's ability to provide the commodity-service is mystified—making it look difficult, far beyond the reach of the client's, or patient's, own powers—by separating "the performance of the service from the satisfaction of client interests" (51). In other words, the doctor does not give patients what they want, but what only the doctor is able to determine they need. The third step involves making the commodity scarce—reducing the supply, increasing the demand—in this case by limiting the right to practise only to licensed individuals. The British medical profession accomplished this formally through the Medical Act of 1858; in the US, as Burns describes, it was accomplished, though much more informally, through the formation of the American Medical Association in 1847. This process of making medical services valuable by making them rare was further reinforced throughout the last half of the nineteenth century, as medical programs in both Britain and North America became increasingly more complex, lengthy, and expensive; medicine became an elite profession both to its patients, and to those seeking to enter it.

The fourth, fifth, and sixth steps of monopoly formation build on the third by controlling the means by which the public has access to the commodity service. This involves "uniting individual suppliers, driving competitive suppliers out of the market by using various economic tactics . . . persuading the state to eliminate competitors by preferential legal treatment" (Berlant, 52), and restricting group membership. As we have seen, the medical profession made good use of this step to take over the business of midwifery. Medical men represented themselves as having superior knowledge of obstetrics and gynecology by virtue of their university education. They then argued that midwives, with their informal system of apprenticeship, were inadequately trained to provide safe care—but then, since most midwives were women, they were of course barred from the university education that was touted as essential. Even if the universities had been open to women, many midwives were poor women helping other poor women, and so would not have had the financial resources to pay for a formal, mostly theoretical, education.

Once medical men had neutralized midwives as competitors among the middle and upper classes, taking over their sizable business in the process, they worked to further restrict competition from other groups—this was one of the principal aims of establishing the Medical Register in Britain in1858. Being registered gave a British doctor government sanction to practise, sue for fees, and hold government office; one could practise without being registered but only by accepting a loss of credibility and benefits. Again, the British Medical Association, with the government's blessing in the form of the 1858 Act, was able to determine who was registered and who was not: the "nots" included holders of foreign degrees (after Elizabeth Blackwell made that loophole visible by exploiting it) and, as was also the case in America, practitioners of non-allopathic, "irregular" medicine (for example, homeopathy, hydropathy, etc.).[1]

Step seven builds on step three—increasing the value of the commodity-service by fixing prices, "above theoretical competitive market value" (53), again with government support, or at least non-interference. Here, the rationale is that people will respect the commodity more, the more they have to pay for it. In a way, it increases the customers' own sense of status, and thus their willingness to cooperate with the monopolization process, to have the wealth to be able to pay whatever the self-styled elite practitioner charges. Finally, steps eight, nine, and ten all have to do with increasing the monopoly's power by presenting a united front to the world of the market. This is accomplished by a unification of suppliers, the elimination of internal competition through the creation of a code of ethics, and the development of group solidarity and cooperation (54). This was one of the primary results of the formation of the British and American Medical Associations, in that it reduced the competition between the three branches of medicine, and put in place the mechanisms necessary to create new, less divisive classes of medical practitioners, the GP and the specialist. Moreover, by unifying, the medical profession gave itself more credibility and authority to oversee medical education and practice—but again, with powers unique to a monopoly, in that they were (and largely still are) empowered by government to oversee their own conduct. The idea is that only initiates into the profession's mysteries are qualified to monitor other initiates and protect the public, at once exempting the profession from the laws of ordinary people (fortunately, the group's laws parallel the country's laws in most respects), and further increasing their aura of mystery and separateness.

This process of monopolization as practised by the group (individual behaviour always being more flexible) was very effective in its relentlessness and ruthlessness; thus, it is not surprising that women, along with other minority groups –Jewish or black men, for example—found the medical profession so difficult to penetrate (Abram, 64). The women had a double challenge to overcome. On the one hand, many of the male doctors were suspicious of them specifically because they were women, and so posed a variety of problems on a social and moral level. But on the other hand, women entering the medical profession had to deal there with an obstacle encountered everywhere by women hoping to enter a male-dominated line of work: quite aside from their social position, determined by their gender, women were simply and straightforwardly, *competition* (Walsh, 133). And because the process of monopolization was inherently inimical to all forms of competition—no matter from what racial, sexual, or philosophical quarter—women were immediately identified as outsiders who had to be kept out in order for the profession to continue its project of consolidating its power and prestige in society:

> The mass of argument, sarcasm, ridicule, invective, and downright calumny which has been poured out upon the heads of the women who, for the last thirty years, have been trying to study medicine, can only be explained by the constant tendency of all monopolies to strengthen themselves by injustice, as soon as they feel that their exclusive privileges are menaced. (Mary Putnam Jacobi, "Commencement Address," 395)

Consequently, feminist reformers such as Sophia Jex-Blake, and their novelist-supporters like Charles Reade, often found themselves disparaging the exclusionary characteristics of the profession—the same characteristics which made the profession a desirable, because elite, goal for women's educational and career ambitions. Jex-Blake, and many others, quickly realized that many of the arguments used against medical women on the basis of preserving their feminine purity and womanliness were actually made of straw, raising the question of why, for example, it was acceptable for nurses to have access to medical knowledge and harrowing hospital experiences, but not lady-doctors. Jex-Blake recalls one of her male supporters, Dr. Thomson, chastising his colleagues for their hypocrisy on this point: "It appears . . . that it is most becoming and proper for a woman to discharge all those duties which are incidental to our profession for thirty shillings a week; but if she is to have three or four guineas a day for discharging the same duties, then they are immoral and immodest, and unsuited to the soft nature that should characterize a lady" (Jex-Blake, *Medical Women*, 192). Could the difference really come down to the vulgar matter of money?

The answer from many critics of women's medical education was a brazen "yes," as they framed their arguments quite frankly in economic terms. Many medical students, for example, were concerned that the "feminization" of medicine would devalue their own degrees, by "lower[ing] the prestige of any institution to which [women] were admitted as co-workers or fellow-students with men" (Jacobi, 394):

> We know a very distinguished graduate . . . who told us frankly what his motives are. "I have," said he, "invested some hundreds of pounds in my education, and what I have to show for it is this degree of M.B.Ed. Had I known there would ever have been a chance of women taking this M.B., I should have gone somewhere else and got another which they could not take . . . I have a personal objection to wearing a degree that is or may be

> worn by a woman." (*The Scotsman*, Jan. 30, 1872, qtd.. in Jex-Blake, *Medical Women*, 193[fn.])

Medical school graduates worried that an inferior class of female doctors would give the whole profession a bad reputation; this despite the fact that the majority of women students, no doubt strongly motivated by their own sense of themselves as an "immigrant" group, as it were, worked hard to equal, if not surpass their male classmates. As Rhoda Gale points out in *A Woman Hater* (1877), "the average male is very superior in intellect to the average female; and . . . the picked female is immeasurably more superior to the average male, than the average male is to the average female" (203). Perhaps the average woman, with her below-average girls'-school education, could not compete with the average man; but the women pursuing medical education were not average at all, as evidenced by the Edinburgh women's performance on their professional exams: in 1875, for example, "[f]our of the five [women students] were on the honours list in chemistry and physics and all five were on the list in botany. Out of 140 men, this was matched by only 31, 25 and 32 students respectively" (Blake, 123). The results of the 1884 medical exams at the University of London offered further proof that the women students, though a small group, were equally capable of meeting the standards set by their profession:

> Now as regards degrees in Medicine. For the first professional or "Preliminary Scientific" Examination, 1027 men went up and 538 passed, or 52.3 per cent.; 20 women went up and 12 passed, or 60 per cent.
>
> For the second or "Intermediate Examination in Medicine," 431 men went up and 240 passed, 55.6 per cent.; 7 women went up and 6 passed, or 85.7 per cent.
>
> For the final M.B. Examination, 116 men went up and 91 passed, or 78.4 per cent.; for this only 3 women had gone up . . . and *all* have passed, *i.e.*, 100 per cent. (Jex-Blake, *Medical Women*, 221-222)

Would it not be better, medical women argued, for one of these above-average women to supplant an average man, if it meant better care for patients?

To supporters of the women's medical movement the negative reaction of medical men smacked of nothing less than trades-unionism. Despite the common modern pairing of feminist and labour movements, many early feminists were apparently greatly in favour of laissez-faire economics as offering them the best chance to prove themselves to the public:

> Free-traders urge that all artificial restrictions upon commerce should be removed, because that is the only way of insuring that each country and each locality will occupy itself with that industry for which it has the greatest natural advantages, or the least natural disadvantages. In like manner, we say, remove the artificial restrictions which debar women from higher education and from remunerative employments (they are already free to perform, if they choose, many kinds of important unpaid work); and the play of natural forces will drive them into those occupations for which they have some natural advantage as individuals, or at least into those for which their natural disadvantages are least overwhelming. (Fawcett, "The Future of Englishwomen: A Reply," 352).

Even those observers who may have disapproved of women doctors objected still more to the trades-unionist strategies practised by so many male professionals:

> Trades-unionism is as universal as trades and professions, and from the bishop to the scavenger all men are hornets if you propose to touch their purse. The claims of women for medical education, and the right to use that professionally, are thus opposed to all the common prejudices of the unreflecting, and this dead weight must be lifted before the claims will be admitted. But the bitterest fighting is with the professional doctors, whose craft seems in danger, and who have put on the whole armour of hornets to

> fight the women on this question. The doctors do not confess that their object is monopoly of a lucrative profession. Oh no! they wish to preserve the morals of society, maintain medical standards that will ensure scientific treatment of disease. But this does not impose on many, any more than the cant of the operative, who wishes his wages raised to put him on a more respectable social status, while he is thinking all the while how many extra pints of beer he is to gain by the change. (*Border Advertiser*, Aug. 30, 1872, qtd. in Jex-Blake, *Medical Women*, 81nCC)

As Blake points out, many male observers regarded the medical profession with suspicion for varied reasons; some disliked the profession's resemblance to a working-class labour organization, while others disapproved of doctors' aristocratic, elitist pretensions. But "what supporters were clear about was their distaste for any legal or institutional barrier which hindered the operation of 'free trade' in the field of employment. They saw both 'trades-unionism' and 'monopoly' as opposed to the 'spirit of the age'" (Blake, 173).

Nevertheless, despite the transparent rhetorical contortions employed by medical men, they still had the real power of the monopoly on their side. They formed the majority group, and even when governments and universities began to concede to feminist demands for equal treatment, the medical profession, with its monopolistic, autonomous control over sanctioning membership, was still able to exclude women from crucial areas of participation:

> It is one thing to establish an abstract right . . . it is another thing to establish a claim to share the privileges which have been won by centuries of labour and expenditure by those who, not content with the abstract assertion of rights, have exercised them for the good of mankind, and founded upon them institutions of great importance and time-honoured traditions. The universities, colleges, and medical schools have been built by men for men, and have been paid for by men. That seems to me a fair

> ground for the monopoly [of which others complain]. ("A Misogynist," *BMJ* Feb. 12, 1876, 202)

The newly formed Obstetrical Society, for example, refused to accept Elizabeth Garrett Anderson onto its lists, with the excuse that the presence of a woman at Society meetings would make men feel awkward. Garret Anderson replied by wondering how men "of such ultra-fastidious refinement" could manage with their patients, if their delicacy was so easily upset by a woman practitioner (*BMJ*, Aug. 17, 1878, 255). Similarly, members of the British Medical Association tried to exclude women on the grounds that the wording of the group's constitution would make the admittance of women impossible. Joseph Lister, the great man himself, threatened to resign his membership if women were admitted under these circumstances: " . . . as the idea of any woman being likely to become a registered medical practitioner was far from the minds of the founders and original members of the Association, the words 'registered medical practitioner' must be held to be exactly equivalent to the words 'male registered medical practitioner'" (*BMJ*, Feb. 9, 1878, 212-213). Women like Dr. Frances Hoggan felt pressured to resign their membership, rather than be held responsible for depriving the association of its star members, and bringing about the disruption of the Association altogether.

Moreover, where overt exclusionary policy failed, more subtle forms of discrimination prevailed: women students, for example, often found difficulty in securing residencies for the latter part of their training; or, once in practice, they found that the support, cooperation, and mentorship provided by male doctors could be scarce indeed as they were left out of the proverbial old boys' network.[2] The feminist community, including its female medical members, was very tight-knit and supportive, but even by the turn of the century, and after decades of struggle, there were still often not enough women doctors in high-ranking faculty positions to go around as mentors and role models. Even the most experienced women doctors found it difficult to secure research positions or professorships at those hospitals and universities not run for and by women. And the final line of defense available to the male monopolists was the most subtle of all: as I will explain below in my analysis of *Dr. Edith Romney*, women doctors, despite their knowledge and skill, were still often regarded by potential patients and important social contacts as mere women, thus making it harder for them to achieve credibility, respect, and high fees in some markets.

To what extent did women doctors actually threaten the prosperity and practice of medical men? Did women really practise medicine differently than their male colleagues? In response to the first question, women doctors and their supporters would reply that they offered little threat at all. While feminists may have had hopes for gender parity in the professions, they had to acknowledge that for the foreseeable future at least, the numbers would probably be low. Part of the problem was that women had been so successfully excluded, not only from the professions, but from the appropriate education necessary to pursue them, for so long that changing the balance would not be accomplished overnight. Women themselves were also partly responsible: as long as they were content with the limited, but apparently idealized, role provided them by the status quo, they would not offer a serious challenge to men in the marketplace (Morantz-Sanchez, 304).

Moreover, as feminists emphasized, the goal of reform was not a predatory displacement of men, but a fair and judicious dispersal of skilled women across a variety of personally and financially satisfying careers. Thus, while medicine was held up by feminists as one of the highest educational and professional goals available to women, it was only one possible goal among many, and nothing for any one profession to become territorially concerned over. The fact was, that while universities, colleges, and training institutes were seeing significant increases in female students in other areas, female medical students made up only a modest percentage of their numbers. Indeed, the medical women's movement ended up as something of a victim to the success of the larger project of opening higher education to women. One of the reasons historians provide for the relative decline in the number of woman doctors after World War I is that by this time there were so many other career paths open to women, they could comfortably afford to eschew the expensive and arduous course of medical study in favour of a variety of lucrative and satisfying occupations (Morantz-Sanchez, 310).

In terms of real numbers, there were over 7,000 women doctors in the US in 1900, out of about 130,000 doctors total, or between five and six percent. In the 1860s and '70s, when American medical women were only starting out, they accounted for between four and eight percent of the total medical profession (Walsh, 186). By 1912 (numbers before this are unreliable to non-existent), the number of women admitted to the Medical Register in Britain was about 600 (Flexner, *Medical Education in Europe*, 325); for comparison, the total number of physicians in the United Kingdom in 1907 (the latest year Flexner cites) was 39,827 (29). In other words, despite their high visibility as political symbols, women made up only a small proportion of the medical profession and so did not, in fact, pose a significant economic challenge to male doctors. As medical women themselves claimed, the only male doctors who need fear female competition were those who were either incompetent or simply too insensitive to their patients.

Moreover, women doctors also tried to promote their own womanliness and propriety, while at the same time minimizing the threat of their competition, by insisting that they would only attend to women, children, and the poor, leaving plenty of patients for their male colleagues. Male doctors frequently did not mind if medical women took on the poor, since they were not a great source of income, but they were not so easily appeased when it came to their middle-class female patients. As the male medical profession had discovered in taking over the business of midwives, women actually accounted for a great deal of business, first with pregnancy and delivery, then with the care of their children, and finally with the large numbers of mysterious women's ailments that seemed so prevalent in the nineteenth century.[3] While women doctors as a group never did reach a size large enough to seriously damage this corner of the male professional's market, their high visibility in the press, combined with their well-intentioned efforts to appear womanly by only targeting women patients, actually served to make their incursion into the male domain *seem* all the more damaging.

In reality, women did live up to their stated intentions regarding patients. Most of the hospitals established by women for women's medical education specialized in treating women and children; and since in the nineteenth century middle-class patients could more easily afford home attendance, most of the hospital's patients also tended to come from the lower classes (this was also the case in male-run teaching or charity hospitals). Many women did run successful private practices, however. Robert Wilson reported that the woman just starting out in practice in England could expect to begin with £200 per year and build from there (30). The fictional Dr. Zay is said to make between three and five thousand dollars per year (Phelps, 86-87); this is in keeping with other, non-fictional, estimates , such as that described in a *Woman's Journal* report on Dean Rachel Bodley's commencement address to the Women's Medical College of Pennsylvania in 1881. In a survey of 189 out of 276 graduates from the previous three decades, 109 reported that they were still in practice, mostly in the north of the US, and mostly in the obstetrical field; the average salary was $2907.00, or roughly three times what a male white collar worker would make. Four women reported incomes of up to $15,000-20,000 per year ("Educated Woman," 150-151). But what attracted very large numbers of women doctors was, in North America, practice on the frontiers, and in Britain, practice abroad as medical missionaries. As I will explain further in Chapter Three, women in the colonies were seen as an especially, and shockingly, under-represented group, badly lacking in basic medical care. Of special concern were those women living in harems or zenanas, since their cloistered status made male medical attendance difficult to impossible.

Feminists had always argued that female doctors would bring special talents to medical practice that only womanly women could provide. Their female patients would feel more comfortable confiding in them and being examined by them. The women doctors would, by virtue of their own feminine nature, have a superior capacity for compassion and empathy, as well as a greater respect for their patients' delicacy—all of which would in turn ensure more accurate diagnosis and treatment, as well as earlier preventative intervention. Women doctors further defended their right to practise because of their innate, womanly dedication to self-sacrifice and nurturance, already highly developed as part of their historically traditional feminine training as daughters, and potential mothers: "I maintain that not only is there nothing strange or unnatural in the idea that women are the fit physicians for women, and men for men; but, on the contrary, that it is only custom and habit which blind society to the extreme strangeness and incongruity of any other notion" (Jex-Blake, 7). Medical women argued that, precisely because they were women, they would not simply cure, but care, offering, as Morantz-Sanchez puts it, sympathy as well science.

As Morantz-Sanchez has demonstrated in her study of American women's medical practice, female doctors lived up to their claims in many respects, choosing modes of practice which focussed on women and children, and which emphasized hygiene and preventative medicine: they practised general, family medicine, and worked as social workers and public health officers. As Glazer and Slater further observe,

> professional ideals also required that true professionals should serve the greater social good, which meant that one's expertise should be offered to those in need . . . For women, who already had a long tradition of unpaid service for charitable purposes, this expectation was particularly attractive. The capacity to assuage the misery of the needy and to nurture the downtrodden in an increasingly impersonal society often provided the necessary legitimacy for women to move from the home to the marketplace. (229)

Women also tended to resist the new trend towards increasing specialization. On the one hand, many medical women wished to avoid promoting what was then suspiciously regarded as a narrowly focussed, and thus inferior education—and so did not go into such areas as ophthalmology or dentistry as many had expected. On the other hand, "women physicians continued to criticize the narrow professionalizaton and crass materialism that they often found characteristic of their male colleagues, offering instead the compassionate dedication to serving others that they themselves considered woman's particular strength" (Morantz-Sanchez, 183). When they did specialize, however, many chose woman- or family-centred fields such as obstetrics and gynecology. The rewards of such choices were clear to the women who made them; unfortunately, female practitioners discovered too late that their aims of improving the health of women and the poor were often irreconcilable with the aim of promoting the interests of medical women as a group:

> the overwhelming thrust of male professional life subordinated service considerations and rewarded those who pursued "careerist" goals and the "main chance." When these two goals became incompatible, women, who constituted the more marginal group, often chose merit and service, while the male-dominated professional organizations ordinarily opted first for the rewards of professional control. (Glazer and Slater, 231)

Nevertheless, Morantz-Sanchez has further observed that while many women doctors were committed to the ideal of both curing and caring, this did not guarantee that their modes of practice were radically different from any perceived "male" style. In her comparison of patient medical records from the female-run New England Hospital and male-run Boston Lying-In Hospital, for the years 1873-1899, Morantz-Sanchez demonstrates that women doctors did seem to show more interest in their lower-class women patients than their male counterparts. For example, the women provided more detailed charting, including more information about the patients' mental and moral states, and tended to prescribe more medications for the sake of comfort, as well as for purely functional, curative purposes.[4] However, in terms of the actual kinds of medicine practised, the women did not differ significantly from their male colleagues, prescribing similar medications and treatments for patients with similar ailments: Morantz-Sanchez found that late nineteenth-century women doctors were no more or less likely than men to practise either heroic, allopathic medicine (including bleeding and purging), or alternative forms of medicine such as homeopathy or hydropathy.

The late nineteenth century was a time of increasing scientific and medical knowledge, existing alongside more stubbornly-held, old-fashioned medical ideas, and women were often just as likely as men to espouse the approaches dominant in their chosen field, whether those approaches were traditional or progressive. In those cases where women favoured more old-fashioned approaches—for example, combining medical care with heavy-handed moral instruction—the results could be attributable both to gender differences, as well as to

> a conflict between old and new concepts of professionalism. In the middle of the nineteenth century, doctors of both sexes believed in the medically curative powers of morality and natural living—a belief that technocratic male physicians increasingly abandoned after 1880. Male doctors apparently surrendered their concern with morality more quickly than did women, and one suspects that female physicians' traditionalism in this instance had much to do with their investment in Victorian culture's identification of women as the moral guardians of society. (Morantz-Sanchez, 227)

In fact, as Glazer and Slater point out, women were often more likely to choose conventional, mainstream modes of medical practice, no matter how male-oriented, as a means of appearing non-controversial (55). Again, as Morantz-Sanchez suggests, even though many women doctors chose medicine out of a commitment to advancing the cause of women's rights, they did not, by any means, necessarily share a late twentieth-century set of assumptions about the role of women in society. Medical women often defended their sex against male charges of inferiority or unfitness by claiming that women could be as intelligent and competent as men: this was not the same thing, however, as abandoning any beliefs in the inherent, natural distinction between the sexes. Many women doctors believed firmly in education and careers for women; they also believed just as firmly in the idea that motherhood was Woman's best destiny, or that women were physically more susceptible to certain mental and physical conditions than men:

> It is hard not to conclude that, although women physicians had a greater awareness and sensitivity to women's issues than men, their overall medical opinions tended to reflect professional and scientific trends and their divergences among themselves often appeared to be similar to those of male doctors. Just as men lacked unanimity on many medical issues, women physicians also differed significantly with each other. As females struggling to strike a balance between science, professionalism, and their own womanhood, they were bound to develop individual solutions to the problems of female health. The historian is hard pressed, therefore, to uncover a uniform approach among these women on how to treat, diagnose, or prevent illness. Women internalized many "male" values, just as men were sometimes advocates of "female" positions. (Morantz-Sanchez, 222)

II. Economic Competition and Emotional Conflict in the Doctress Novels

As we have seen, many of the doctress novels are concerned with making their medical heroines appear as models of professionalism. But while these novels stress the woman doctor's competence, reliability, intelligence, and strength, the reader also gets the sense that the novels' creators are anxious to make it clear that the female professional is still a lady, still a woman—and thus not a competitive threat to men, either in medicine, or in the larger middle-class social order. These novels are romances after all: according to DuPlessis' definition, the romance, or marriage, plot can be characterized by "the use of conjugal love as a telos and of the developing heterosexual love relation as a major, if not the only major, element in organizing the narrative action" (200n22). Thus, because of generic conventions, the structure of most doctress narratives emphasizes the emotional development and interactions of the characters over a fidelity to complete, naturalistic detail.

Even in the cases of those novelists, such as the Americans Howells, Phelps, and Jewett, who were avowed realists, the plots of their doctress novels are nevertheless organized according to romance conventions—most notably, through a focus on the emotional condition of the female protagonists, especially as seen in their relationships with men.

And as I suggested in the Introduction, while the figure of the woman doctor does exist in these romances as a politically resonant figure—she is not employed merely for the sake of novelty—the manner in which she is represented, and the manner in which the narrative expresses its political attitudes in regard to her, are also governed by the romance's preference for emotion over logic or fact. So while many of the doctress novels do make a case for woman's fitness for professional life, they are also bound to deal with her potential fitness for romantic life as well. The result is a focus on her character, as both woman and professional—who and what she is, rather than simply what she does.

And this is really not all that different from the way in which male doctors are represented in fiction of the day. Unlike modern fiction, which contains the medical thriller or hospital drama as a subgenre complete with all the gory, expertly rendered realist details,[5] many Victorian novels featuring doctors focussed on the nature of their character, as either evil scientific genius or noble medical hero.[6] When a novel does bring in any detail of medical practice, it is only in the further service of such character delineation. The sensibilities of Victorian readers may not have been too delicate to handle the realistic portrayal of medical practice—after all, the newspapers, for example, did very well in their graphic coverage of the Jack the Ripper mystery—but it seems as though it was a tacitly understood feature of the romance genre of the time to spare the reader in that regard.[7] Readers did not want to see their manly male heroes faced with festering wounds or untreated tumors. Thus, it is hardly surprising that romance writers would be similarly careful to keep their representations of the womanly female doctor focussed on her interpersonal experiences rather than her medical duties. The goal of the romance is to bring two suitable characters together. A perceived excess of detail, especially those details pertaining to competition between economic and sexual rivals in the *business*, rather than the practice of medicine, might inject serious obstacles to such a project, particularly if they in any way jeopardized the portrayal of the woman doctor—and romantic protagonist—as inappropriately treading on masculine territory.

As a result—as I pointed out in Chapter One—the full details of medical practice rarely intrude into the clean, orderly romance which makes for the woman doctor's primary residence. For example, most of the novels hardly discuss life at medical school at all. Most notably, while occasional references to lessons or treatments do occur, the contact, and competition, real medical women would have had with male classmates is practically invisible within the texts. When life at medical school is referred to, it is, first of all, almost always a thing of the past, a trial undergone, endured, and successfully managed. Moreover, the novels are also rather forgiving of any past slights at the hands of male students and instructors. Charles Reade's Rhoda Gale asserts that in both Scotland and France she met with nothing but courtesy from at least some men; Henry Curwen's Dr. Hermione had to deal with some masculine unpleasantness, but now, having proved herself by achieving her medical degree, she can put all that behind her. In the story, any medical school difficulties appear and disappear as a passing comment: "I have stood worse banter than that in my day" (32).

Rhoda Gale (*A Woman Hater*, 1877) is the only female medical student who directly discusses the difficulties of competition with men. In telling her version of the battle at Edinburgh, Rhoda pulls no punches and makes it clear that the only thing standing in the way of medical women is male fear of competition, manifested in immature pranks and unfair trades-unionism:

> . . . was it in nature, then, that the medical union would be infinitely forbearing, when the Legislature went and patted it on the back, and said, *You* can conspire with safety against your female rivals? . . . Against unqualified practitioners they never acted with such zeal and consent; and

> why?—the female quack is a public pest, and a good foil to the union; the qualified doctress is a public good, and a blow to the union. (Reade, 197)

Charles Reade makes Rhoda's story parallel to that of Sophia Jex-Blake and the other women at Edinburgh, and makes use of the same anecdotes that Jex-Blake and her followers themselves used in publicizing male jealousy and foul play. By the end of her account, Rhoda has completely convinced Vizard (the self-professed Woman Hater), that women's claims to medical education have nothing to do with their femininity—that is never in question—but everything to do with male insecurity and coarseness: " . . . your blood would boil at the trickery, and dishonesty, and oppression of the trades-union which has driven this gifted creature to a foreign school for education, and now that a foreign nation admits her ability and crowns her with honor, still she must not practise in this country because she is a woman and we are a nation of half-civilized men" (234).

And Vizard is not the only one convinced. Not only does the narrator feel strongly enough about the cause of women's medical education that he breaks the flow of his romance narrative for over fifty pages in order to give Rhoda—only a supporting character in the romance—her chance in the spotlight to make her case; he also concludes his romance with a lengthy editorial on the need for fairness in the treatment of women doctors. The loose ends of the romance are neatly tied up; all the characters are happily accounted for; and the narrator—a self-professed woman-hater suspiciously like Vizard—turns the happily-ever-after ending into a lecture on the evils of trades-unionism and obstructive labour practices, and the need for an Enabling Bill (passed in 1876) to allow equal opportunity to medical women:

> Should a law be passed . . . [t]he larger half of the population will no longer be unconstitutionally juggled, under cover of law, out of their right to take their secret ailments to a skilled physician of their own sex, and compelled to go, blushing, writhing, and, after all, concealing and fibbing, to a male

> physician; the picked few no longer robbed of their right to science, reputation, and bread. (531)

In contrast to Reade's more forthright approach, other authors seem to evince a desire to emphasize the non-threatening womanliness of their medical heroines' professional career choices, to the extent that medical practice and the problem of competition with other male doctors do not figure prominently in many of the other doctress novels. The economic reality behind the medical woman debate proved to be incongruous to the demands of both form and content, with the result that most of the novels avoid the issue altogether, allowing the romance form to influence the fictional representation of a real-life controversy. As a result, the predominant narrative strategy of most of the doctress novels is to manage the problem of medical work for women as a psychological or emotional conflict. All of the doctress novels have, as a central preoccupation, the issue of what constitutes true womanly femininity. Even when the portrayal of professional life is shown as a positive choice for women, it is made to be so because it does not undermine the stereotypical view of essentialized womanhood so central to middle-class ideology of the day.

Thus, as a result of both the novel's generic constraints, and the political motivation of the authors, both the form and content of the doctress novels work to establish the central conflict for the medical woman as one of identity, a choice between two competing versions of womanhood: the domestic angel and the New Woman. But they also work to ensure that this conflict is located entirely in the psychological, emotional realm of romantic fiction rather than in the realm of more realistic, economic struggle and competition. This keeps the conflict for the woman doctor focussed on issues of femininity, rather than on issues associated more with masculinity, like competition for money and status in the marketplace. By anchoring the conflict in essentialized notions of gender in this way, the novels are able to conform to the demands of the conventional romance genre to be stable and non-controversial, so that the question of female education and increased independence is safely contained within an exploration of a modified, but nevertheless intact, vision of middle-class femininity.

The result is a series of female protagonists who, with only one notable exception (Dr. Edith Romney), are removed from the scene of economic competition with men. This competition is displaced from the public, external realm—and any male hostility that might be encountered there—into a private, internalized form of competition, as the female medical professional must choose between traditional, conventional expectations regarding marriage and motherhood, and the more unconventional attractions of professional independence. For the woman engaged in this internal conflict, men are almost never enemies or rivals, at least not for long. Rather, male characters tend to act either as patrons and mentors—especially as father figures—or, more importantly, as catalysts for the struggle, forcing the medical woman to confront her true nature by tempting her with romance and the prospect of marriage.

The choices she makes in reaction to these catalysts tend to follow three patterns, which I will explain in more detail below. These patterns can be read as the narratives' positions on the question of whether women can indeed have both a career and a personal life, while still retaining their femininity and enjoying the fulfillment of essentialized feminine desires. The first of these patterns is best exemplified by William Dean Howells' *Dr. Breen's Practice* (1881) and Henry Curwen's *Dr. Hermione* (1890). Here, the choices between personal life and career are seen as fundamentally incompatible, and when it comes time to make a decision, the medical woman bows to stereotypes and opts for the role of "Woman" over medicine. Or, one could say that the medical woman opts for "Man"—the potential husband who offers her the socially sanctioned means of achieving her feminine destiny as a wife and mother. In the second pattern, the medical woman's relationship to men is felt more as an absence than a presence. In the cases of Rhoda Gale (*A Woman Hater*, 1877), Dr. Janet (*Dr. Janet of Harley Street*, Arabella Kenealy, 1893), Nan Prince (Sarah Orne Jewett, *A Country Doctor*, 1884), and Victoria (*Dr. Victoria,* G.G. Alexander, 1881), the conflict between professional and personal choices is not resolved through economic or romantic relationships with men. Rather, it is resolved—or evaded—by the gradual erasure of the need for, and possibility of, such relationships by making the medical woman celibate.

The third pattern is the one that actively seeks ways to render possible the balance of professional success and romantic fulfillment. The doctress novels in this category still tend, with the rare exception, to avoid dealing directly with the challenge of economic competition with men. At the same time, however, they all share in a commitment to constructing positive portrayals of a new kind of relationship, where the New Woman is matched with a suitably worthy New Man. Here, interestingly, it tends to be the male protagonist who undergoes the most development of character. In these cases, the conflict for the woman doctor is often (though not always) a consequence of having to wait for the New Man-elect to learn from his experiences in the narrative to put aside his old-fashioned prejudices in favour of a more progressive, equitable relationship with the woman doctor.

Convention Prevails Over Professional Ambition

It seems to be no accident that those novels which follow the first pattern, where marriage prevails over professional ambition, are also the novels that question women's actual fitness for medical work. These novels seem to ask not, "is a medical career a better choice than marriage?" but rather, "do women even have what it takes to pursue a medical career?" In the case of both William Dean Howell's *Dr. Breen's Practice* (1881) and Henry Curwen's *Dr. Hermione* (1890), the issue of women doctors' ability to compete with men in defiance of their essential womanly natures is settled in men's favour.

Howells' Dr. Grace Breen is "a spirited and carefully worked up study of just the kind of woman who never ought to have undertaken a medical career" (Jex-Blake, "Medical Women in Fiction" 265). In fact, I suspect many woman doctors would agree that, given Grace's unsuitable reasons for pursuing medicine in the first place, her ineffectual response to her first, and nearly last, case is hardly cause for surprise: "That such a character and such a history are possible, no one probably will dispute; but those who know even a few of the hundreds of hard-headed, cool, and capable medical women of America can hardly avoid regret that it was not one of these that was taken as the type to be portrayed on Mr. Howells's picturesque canvas" (266).

Grace decides to go into medicine after a bad love affair, for reasons that have as much to do with her need for a positive outlet for her desire to love and comfort as with her commitment to altruism. In short, she is a prime example of then-current stereotype surrounding middle-class working women, especially nurses and doctors. She is not working out of any strong commitment to an ideal of women's education and independence; rather, her choice of medicine seems to be a substitute for her preferred, natural role as wife and mother: "If I had been a man, I shouldn't have studied medicine . . . I wished to be a physician because I was a woman, and because—because –I had failed where—other women's hopes are" (43). But without a strong sense of purpose, or a strong belief in her own abilities, Grace lacks the focus and decisiveness so necessary to the competent medical professional.[8] From the beginning, Grace seems, by her own admission, unable to look after herself, let alone care for her patients. She wants to prove that women can be professionals, but does not seem to believe in the principle herself:

> A woman is reminded of her insufficiency to herself every hour of the day [Grace says]. And it's always a man that comes to her help. I dropped some things out of my lap down there, and by the time I had gathered them up I was wound round and round with linen thread so that I couldn't move a step, and Mr. Libby cut me loose. I could have done it myself, but it seemed right and natural that he should do it. (44).

Grace, the would-be medical woman and crusader for women's self-sufficiency, is unable to escape from the most basic symbol of feminine domesticity, her own sewing. She recognizes the problem, and her own surrender to it by relying on Libby to help her; but she lacks the conviction to take charge of the physical, and ideological, traps that bind her.

Similarly, when her professional role is challenged for the first time, she finds that she is unprepared to summon the necessary competence and authority, and again feels herself forced to turn to a man for help.

Her first case, the care of Louise Maynard and her delicate chest, is complicated medically by a psychological battle of wills between Grace and Mrs. Maynard. Grace does not want Mrs. Maynard, who is separated from her husband, to go for a sail with Mr. Libby because of the harm it could do to both her health, and her reputation. But since Mrs. Maynard regularly scoffs at Grace's advice, Grace will not order her, and she will not resort to tricks; Grace ends up encouraging her patient to go for want of any better policy to take with her. After Mrs. Maynard and Libby are caught in a storm, and Mrs. Maynard promptly develops pneumonia, Grace is wrecked with guilt and self-doubt. When Mrs. Maynard, a stereotypical woman patient inclined to emotional weakness and hysteria, begins to panic, she demands to see a real doctor: "I can't be trifled with any longer. I want a man doctor!" (64). At first Grace demurs, thinking that Mrs. Maynard is more nervous than ill; but her diagnosis turns out to be incorrect. Alarmed, and feeling "as nervous and anxious as her patient" (77), Grace reluctantly concedes the case, unsure how to proceed on her own.

Further reinforcing her lack of professional knowledge is the fact that she is a homeopath. In the US, homeopathy and other "irregular" approaches to treatment were taken seriously by many as a valid form of treatment, especially because they tended to be far less invasive than allopathic, or "regular," medicine. As Jurecic points out, for much of the nineteenth century many physicians practised a bit of both methods—in the absence of modern medical discoveries, often one method seemed as useful as the others (104). However, by the latter decades of the century, allopathy, bolstered by new scientific advances, started to become the dominant form of medicine taught and practised by the mainstream medical profession; from the 1880s on, the most prestigious medical schools were dedicated to allopathic practice. Homeopathy and other forms of alternative medicine were still practised at smaller schools, but they were becoming increasingly marginalized in the medical community out of a belief that they had lower standards and less rigorous curricula—and, incidentally, they were also known to permit the admission of women and minority groups where the larger schools did not. Consequently, it became part of the American medical profession's monopolistic strategy to denigrate homeopathy as "quack" medicine, which in turn damaged the reputation of those schools with a homeopathic approach, not to mention the reputation of their already-marginalized female graduates.

Thus, when Grace goes to town searching for a male doctor she can call in for a consultation, her defeat is compounded when she discovers that she must call on Dr. Mulbridge—an allopath. Although there were few federal laws regulating the practice of regular and irregular medicine, according to the ethical code established by the American Medical Association in 1847, Mulbridge does risk disciplinary action and expulsion by consulting with a mere homeopath (Burns, 41). Consequently, Grace is forced, for the sake of her patient, to surrender the case to him entirely, staying on only as his nurse:

> I have no right to endanger another's life, through any miserable pride, and I never will. Mrs. Maynard needs greater experience than mine, and she must have it. I can't justify myself in the delay and uncertainty of sending to Boston [for another homeopath]. I relinquish the case. I give it to you. And I will nurse her under your direction, obediently, conscientiously. (102)

To Dr. Mulbridge, Rochester-like in his rough manners and craggy looks (171), Grace is an object first of pity, then of love. He concedes that her treatment of Mrs. Maynard has been exemplary, and that Grace's medical expertise is actually "as respectable as that of any clever young man of their profession" (119). Nevertheless, he believes that Grace is too young and girlishly emotional to be a doctor, at least on her own. She would, however, make a good wife and junior partner to a husband who would know how to teach and direct her: "The chances are that she won't have the courage to take up her plan of life again, and that she'll consider any other that's pressed home upon her. . . she has formed the habit of doing what I say, and there's a great deal in mere continuity of habit. It will be easier for her to say yes than to say no" (204). Thus the issue of professional competition is satisfactorily resolved for Mulbridge; to him, Grace is more of a patient, a woman to be rescued, than a rival—but not because of her professional affiliation with the "irregular" practice of homeopathy. As Jurecic observes, "his refusal to accept her [as a colleague] has its basis in misogyny more than medical philosophy" (108).

In fact, neither Mulbridge nor the narrator seems to be afflicted with professional prejudices, and they can be magnanimous towards accomplished medical women. Mulbridge, for example, is made to speak "with real deference" (97) of American women like Mary Putnam Jacobi, who had been prize-winning students in Paris. The novel seems disingenuously to suggest that there should be no obstacle to women who wish to enter the professions. And if there are obstacles, it is not men who create them, but women themselves, as Grace herself is made to realize: "Every woman physician has a double disadvantage that I hadn't the strength to overcome,—her own inexperience and the distrust of other women . . . It is the men alone who give women any chance. They are kind and generous and liberal-minded" (221). As even Mrs. Maynard can see, it is the women around Grace who doubt her the most, and who are most inclined to cling to the prejudice that being a doctor is "much more scandalous than [being] the greatest flirt alive" (30). Even Grace's mother thinks Grace is "too weak to practice alone" (232).

But the novel suggests that even more damaging to a woman's chances than the lack of support from other women, is her own lack of confidence, and her inability to think of herself outside the boundaries of convention. For example, while Mulbridge has every intention of dominating Grace were they to marry, he sees no reason why she could not continue to practise: "Under my direction, you have shown yourself faithful, docile, patient, intelligent beyond anything I have seen . . . You can't do anything by yourself, but we could do anything together" (228). It is true he is offering her a skewed vision of equality, but Grace turns down his offer of marriage and partnership not just because she sees him as a tyrant, but because she is simply uninterested in the *professional* life he would offer her. Grace feels defeated by her first case, and by the humiliation of having to give way to a competitor, without even making a fight of it. Exhausted by the struggle to defend her ego throughout this trial, she decides to give up medicine altogether, and go back to what does seem to be her natural role:

> . . . the waste that I lament is the years spent in working myself up to an undertaking that I was never fit for. I won't continue that waste, and I won't keep up the delusion that because I was very unhappy I was useful, and that it was doing good to be miserable. I like pleasure and I like dress; I like pretty things. There is no harm in them. Why shouldn't I have them? (234)

Grace has been labouring under a sense of self-sacrificing duty—to her mother, and the cause of women everywhere—that has led her to achieve a rare goal for a woman of the time. And yet, poised at a moment where she could go on to solidify the gains she has made personally and politically (she has a job waiting for her, in practice with another woman doctor), she deliberately chooses to retreat, to give it all up for what she herself recognizes as trivial and conventional amusements. Grace has confronted misogyny, in the person of Mulbridge, but the novel suggests that it is the limitations of her own thinking, and not external male bias, which has led to her abandonment of her career.

Grace rejects Mulbridge, and realizes that she has fallen in love with Libby, a young man who seems no more mature than she is, despite what one assumes is her greater experience as a result of her medical training. She goes to great lengths to get Libby to renew his marriage proposal: "She was no longer aiming at a professional behavior . . . she was in fact abandoning herself to a recovered sense of girlhood and all its sweetest irresponsibilities" (238). Libby is not the tyrant Mulbridge is; and seems to offer Grace indulgence instead of control, which further contributes to the reader's sense that the narrative is committed to portraying professional life as completely inimical to the nature of the average young woman.

After being worn out with a life of fun and dissipation on her honeymoon, Grace finds herself practising medicine once again; however, "it was doubtless from a shrewder knowledge of her nature than she had herself that her husband had proposed this active usefulness" (270). Grace has taken the job of medical officer in Libby's manufactory, at his instigation, not hers; and she is working without pay, and apparently with ambivalence and a lack of positive interest beyond an inescapable sense of duty: "At the end of the ends she was a Puritan; belated, misdated, if the reader will, and cast upon good works for the consolation which the Puritans formerly found in a creed. Riches and ease were sinful to her, and somehow to be atoned for; and she had no love for anything that was not of an immediate humane and spiritual effect" (270). At the end of the novel, Grace herself is noticeably silent on her ultimate feelings about her professional and personal choices—and the narrator refuses to narrate beyond an indeterminate ending: "If it has not been made clear from the events and characters of the foregoing history which opinion is right, I am unable to decide" (271). But while the narrator will not make any final assessment about Grace's life, or allow her a final say on the subject, he does report on the "opinions" of certain *ladies* (Grace's mother, and one Miss Gleason, an admirer of Grace) who have observed Grace and find her fate unsatisfactory. Their final assessment is that either she has let down the cause of women by working, for free, for her husband, or that the care of the employees' children is a poor substitute for children of her own. The narrator declines to judge Grace, but he leaves her silent, and gives much of the last word to the kind of fickle and superficial women he has earlier identified as being some of the medical woman's greatest detractors. Although Grace has returned to medicine, after a fashion, the final impression we have of the medical woman is one of ineffectuality, compromise, and ambivalence. The novel places no direct blame, but the ending reminds us of the point that both the narrator and Grace have made earlier, that it is women's own lack of conviction in themselves, and in each other, that will always prevent a happy ending for the female doctor.

To an extent, and as Sophia Jex-Blake conceded in her review of the novel, Howells' portrayal of the medical woman may be realistically accurate, true-to-life in that not all women who chose unconventional paths were necessarily noble revolutionaries. But I would argue that Howells' narrative choices also provide a realistic portrayal of certain male assumptions about women that prevailed at the time: his novel seems to deny male responsibility for any difficulties the professional woman may face, while implicating the whole female sex as being intrinsically unfit for the challenge. As Jex-Blake astutely observed, of all the possible models that Howells could have chosen for his Dr. Breen, he chose the stereotypically flighty and confused girl, rather than the kind of mature and competent woman who *was* available to draw upon. As a result, his realistic portrayal is not entirely rationally objective. Howells may be fair in his portrayal of a flawed protagonist, but his portrayal of the professional, competitive relationship between male and female doctors—while a logical outcome given Grace's character—is needlessly one-sided. As a result, the novel seems to suggest that competition between male and female doctors is destined to favour the former, despite evidence to the contrary provided in real life by "the hundreds of hard-headed, cool, and capable medical women of America" (Jex-Blake, "Medical Women in Fiction," 266).[9]

Like Dr. Breen's situation, the case of *Dr. Hermione* is complicated by the female protagonist's lack of certainty and satisfaction in regard to her chosen career; Curwen's novel, however, unlike that of Howells, makes even fewer concessions to the possibility of women being well suited to the practice of medicine. Dr. Hermione Hartley is first introduced as a model for female emancipation and professionalism: she is beautiful, talented, and apparently possesses a nun-like dedication to her work, to the exclusion of personal concerns (34). But the novel soon points out some troubling chinks in the doctress' armour. Wise, but gruff, old Dr. Jones suggests that Hermione is actually naive, lacking the experience necessary to toughen her up and make a truly dedicated doctor of her. With her wealth, she has the power to choose to practise wherever she likes, but she has chosen to play doctor, it seems, on her own estate: "She knows absolutely nothing of the real world outside her consultation room, and she will very likely fall into the hands of the first young jackanapes with melancholy eyes and a sympathetic manner, who hears of her fortune, and is 'cute enough to insinuate all she has lost by devotion to an impossible ideal" (35). Hermione, it turns out, started out with more noble ambitions, working among the urban poor alongside her socialist friend Mr. Vaughn; but she abandoned the cause because her enthusiasm was not enough to compensate her for the realities of their very difficult work (220).

Based on this history, Dr. Jones teases Hermione that her medical work is only a hobby, to fill her time until the right man comes along. And despite Hermione's apparently sincere belief in the need to work for causes greater than one's individual preferences, that is precisely what happens. Hermione and her friend Edith Falconer become involved with army officers, Tom Thornton and Major Dundas. Their growing romances provide the women with opportunities to defend their career choices, and the cause of women's rights generally, seemingly suggesting that neither Hermione nor Edith would consider giving up their careers for the sake of love, so committed to their political ideals are they: "Hermione's life is my ideal life, and . . . I mean to join her when I am fit for it. Look at the immense amount of misery, far and wide, that no mere man can alleviate" (27). But Edith's references to the pro-feminist portions of Tennyson's *The Princess* also remind Hermione of Princess Ida's maternal longing to keep Psyche's baby; and Dr. Jones' story of a sick woman "cured" by motherhood and marriage disturbs Hermione's once-firm convictions: "If Dr. Jones's story meant anything, it meant that a quiet, unambitious, uneventful home-life is the ideal life after all, with its double joys, and double interests, and double responsibilities" (107).

Hermione's own natural womanliness seems to create conflict within her over the shape of her future. When Thornton and Dundas are called up to battle in Africa, the two women are left behind to wait helplessly for their return. During this period of restlessness, Hermione renews her association with Mr. Vaughn, and as a result begins to reconsider her reasons for leaving her work in the city behind. But through a convenient—or inexplicable—plot turn, when next we see Hermione and Edith they have gone to Africa to join the men, not as doctors, but as nurses, armed with a fine picnic from Fortnum and Mason's. When Thornton is injured, Hermione's professional demeanour completely collapses. She is barely able to care for him as nurse, through her sobs and tears; the prospect of her stepping in to manage his case as a doctor is out of the question. The medical crisis leads to a declaration and proposal from Thornton, and Hermione is only too happy to accept: "I never hurt anybody by being a doctor. I tried my hardest to do good. And you don't know how hard I worked in London before you [Dr. Jones] took me away from it. Surely I was not wrong there. And now, why should I not be as happy as other women are who have never attempted anything at all?" (258).

The novel starts out promisingly in its apparent intention to create a favourable portrait of the admirable female professional, but it ends by making it clear that woman's truest happiness lies in fulfilling her natural destiny as a wife and mother:

> "[Thornton] will make a grand name for himself, and every woman in the world will envy me!"
>
> "My dear! And the grand name you were to have made?"
>
> "It will be changed a little, Dr. Jones, and I will fight for him instead of myself." (259)

Personal ambition, the power to help others—none of that matters, or is as rewarding, as dedicating one's energies, and identity, to love and marriage, centred in the figure of the husband-to-be. In Hermione's case, then, the issue is not economic competition for business and credibility between male and female doctors; rather, it is psychological competition, fought out in the woman's mind and emotions, between the false promises of education, career, and autonomy (or loneliness), and the certain rewards for following the dictates of womanly nature. Curwen, like Howells, seems to conclude that the very existence of this internal conflict between competing options is an indication of the incompatibility of professionalism and feminine nature. Once again, we are presented with a doctress who threatens no competition with men, because she cannot even compete with the seemingly inevitable imperative to fulfill her destiny as *Woman*.

Success Through Sexlessness

The second pattern for the doctress novels assumes, with the first, that the choice between tradition and reform is an either/or proposition. For the authors of these doctress novels, medicine is seen as a noble, essential cause for women—but one that cannot be reconciled with the demands and rewards of conventional female life. Consequently, while Rhoda Gale, Dr. Janet, Nan Prince, and Dr. Victoria all find their highest calling, and their greatest satisfaction, as medical women, they have also been cast as celibate as a result; they are in the romance, but not of it. Any potential threat that these women pose to male economic, or social interest, is neutralized by removing the problematic sexual aspects of their identity. For instance, for Rhoda (*A Woman Hater*, 1877) and Dr. Janet (*Dr. Janet of Harley Street*, 1893), the choice of a medical career over a more "natural" role is explained—justified—by implying that these women are "naturally" celibate.

Rhoda, for example, is not unattractive, but her features do not fit the pattern of romantic heroine as well as Vizard's pretty, but helpless, sister Zoe: "Zoe settled in one moment that [Rhoda] was downright plain, but might probably be that mysterious and incomprehensible and dangerous creature, 'a gentleman's beauty,' which, to women, means no beauty at all, but a witch-like creature, that goes and hits foul, and eclipses real beauty, doll's to wit, by some mysterious magic" (Reade, 252). Nevertheless, despite Rhoda's oft-mentioned witch-like charms, Vizard characterizes her immediately, though good-naturedly, as a virago; and as the story progresses, Rhoda is shown to be much more interested in beautiful women than in handsome men: "Rhoda Gale was not of an amorous temperament, and she was all the more open to female attachments" (388). Rhoda is left single at the end of the novel, when all the other young ladies in the story are married off happily ever after; the novel seems to take it for granted that while Rhoda may possess many admirable qualities, marriageability is not one of them.

In Dr. Janet's case, she herself admits her lack of feminine charms, describing herself as "neuter." When the young Phyllis first meets Dr. Janet, she and the reader quickly understand that whatever role Dr. Janet may come to play in the narrative, it will not involve competition with Phyllis for the job of romantic heroine. For one thing, Dr. Janet, at fifty, is simply too old for the job. Many nineteenth-century physicians believed that middle age and menopause spelled the end of a woman's sexual functions: even if Dr. Janet were not unsexed by her plain, "shapeless" (Kenealy, 86) appearance, and her unconventional choice of career, her age effectively disqualifies her from being anything other than a supporting character to the main action of the novel's romance plot.

While Rhoda and Dr. Janet do not relate to the men in the novels as anything other than friends or "bachelor" colleagues, they do share a strong interest in, and affection for, other women. Rhoda, for example, is shown to be positively infatuated with first Zoe, and then Ina Klosking, proving herself to be as susceptible to their feminine beauty as Uxmoor, Severne, and Vizard. As part of Rhoda's supervision of Ina's recovery, Rhoda bundles her off to her cottage, where "these two friends slept together in each other's arms" (475). Dr. Janet warns Liveing not to tempt Phyllis away from medicine—she does not want a man to interfere in her plans for her protégée. And at this point, since Phyllis is still legally married to her hated husband de Richeville, Dr. Janet believes that if she can belong to anyone else, it should be to her: "Paul [Liveing], I warn you to leave her alone. I won't have you make love to her—I won't let any man make love to her. I want her for myself . . . Phyl, you'll have to become a neuter, I'm afraid. It's your only chance" (143-45). Her feelings for

Phyllis are as proprietary as Liveing's, blurring the line between maternal and spousal affection.

Based on examples such as these, it could be argued that, in attempting to conceptualize a prototypical, believable doctress, neither Reade nor Kenealy (herself a doctor) could conceive of characters who were not "mannish" and who were thus not also possessed of a man's *sexual* interest in other women. However, I would argue that to read Rhoda and Dr. Janet as lesbians is to read too much into their behaviour. It is true that real medical women—like many women of the day—often formed very close personal attachments to other women. Part of Sophia Jex-Blake's initial attraction to medicine may well have been due to her intense relationship with Dr. Lucy Sewell, and throughout Jex-Blake's life she was always involved, and cohabiting with, other women. But as Smith-Rosenberg points out in her article, "The Female World of Love and Ritual: Relations Between Women in Nineteenth-Century America," intimate relationships between women were not at all unusual in the nineteenth century. One effect of the prevailing separate spheres doctrine was to insure that women often shared more time and experiences with female relatives and friends than with men. Women, Smith-Rosenberg argues, could identify better with other women, and could offer one another more empathy and support than the somewhat "alien" men (28):

> It was within just such a social framework . . . that a specifically female world did indeed develop, a world built around a generic and unself-conscious pattern of single-sex or homosocial networks. These supportive networks were institutionalized in social conventions or rituals which accompanied virtually every important event in a woman's life, from birth to death. Such female relationships were frequently supported and paralleled by severe social restrictions on intimacy between young men and women. Within such a world of emotional richness and complexity devotion to and

> love of other women became a plausible and socially accepted form of human interaction. (9)

Within the feminist community, including the network of medical women, such relationships would be especially attractive and necessary. For example, while many medical women married, many others did not: there were few enough men to support the women's causes—there would be even fewer who would be willing to join the social experiment of an egalitarian, two-career marriage. When women turned to one another for support and companionship, doubtless some of these relationships contained a sexual component, but to make a decisive connection between women's intimacy and homosexuality at a time when such sexual identities were only emerging in cultural awareness is extremely difficult.

As far as portrayals of lesbianism in the doctress fiction go, I am unconvinced that either Rhoda or Dr. Janet could be so categorized. Again, for the propagandistic element of the doctress novels to work, they had to convince mainstream, conventional readers that medical women were not controversial; deliberately creating homosexual characters and celebrating non-heterosexual unions would not contribute to this goal. A more plausible explanation for the portrayal of Rhoda and Dr. Janet lies in the problem for the authors of dealing convincingly with the "new" and unfamiliar figure of the woman doctor. Both Reade's and Kenealy's novels suggest that the authors were, on the one hand, committed to the principle of education and professional work for women—but that, on the other hand, they were experiencing genuine difficulty in understanding how to separate "masculine" knowledge from masculine behaviour in the make-up of their doctresses. The authors seem unable to free their conceptions from the influence of the very common belief that "male" education and experience would have an "unsexing" effect on women. The result could only be Reade's "virago" and Kenealy's "neuter"—characters who are mannish enough to be somewhat androgynous, and who possess, as a result, not an inverted sexuality, but a *lack* of sexual interest altogether. This allows these two doctress characters to engage in relationships with those around them, to feel love for others; but, intense as this love may seem to twenty-first-century readers, it falls, I believe, within the realm of acceptable, but sentimentalized, nineteenth-century modes of expression. Since the characters' feelings are not sexual one way or another, they do not create complications for the romance plot, or threaten the primacy of heterosexuality and the clear division of sex roles in society.

The medical profession for women, then, is not meant to compete with the economic, social, or sexual interests of the majority of men, or women. Instead, these novels seem to be building on the superflous-woman controversy that had been present in the popular press from the mid-century on: while most women would want to marry, not all would be able to; not all would be suited to. For these women—like Rhoda or Dr. Janet—excused from the feminine duties of marriage and motherhood, destined to be celibate, some provision should be made for them, and for their feminine powers to heal and comfort. If they are not likely to contribute to society through the formation of families, they can at least be permitted to make themselves useful by caring for the families of others. Society would be safe no matter what profession such women might pursue, these novels suggest, since there are no other, gender-determined roles which could make a more pressing claim for their dutiful attention.

Nan and Victoria are presented somewhat differently. Each is represented as being thoroughly feminine, and the object of male romantic attentions as a result. But their circumstances lead them to believe that their destiny as women lies elsewhere—not because they are deficient in womanly talents and ambitions, but rather because they are exceptionally endowed with the highest and purest womanly qualities of love and maternal nurturance. For them, the practice of medicine is elevated to the status of a spiritual vocation, and they are elevated too, nearly to the status of virgin saints, almost Christ-like in their benevolence and powers to heal.

Sarah Orne Jewett's Nan Prince (*A Country Doctor*, 1884), for example, is portrayed as being very much a child of a natural, organic environment, sanctified by its removal from the corrupting artifice of urban life and the competition for status and power. Her foster-father, Dr. Leslie, raises her to find her education in nature, and to look there for sources of divine wisdom and inspiration, even though it may bring her into conflict with the conventions of earthly existence:

> It counted nothing whether God had put this soul into a man's body or a woman's. He had known best, and He meant it to be the teller of new truth, a revealer of laws, and an influence for good in its capacity for teaching, as well as in its example of pure and reasonable life. (Jewett, 334)

By maintaining her essential purity of mind, Nan is able to see past the fleeting satisfactions of romance with George Gerry, who offers her a life of social position and comfort. Instead, she is receptive to the call from a higher source of wisdom, helping her to see that she has the power to do boundless good in the world as a doctor: "It is only those who can do nothing who find nothing to do, and Nan was no idler; she had come to her work as Christ came to his, not to be ministered unto but to minister" (340). Her personal, sex-specific, desires fall away as she comes to believe in the importance of sharing her gifts with others out of a generous sense of self-sacrifice and service. Nan is tempted by the thought of a conventional life with Gerry, but ultimately puts her personal desires aside out of a sense of a larger duty: "She might be happy, it was true, and make other people so, but her duty was not this, and a certainty that satisfaction and the blessing of God would not follow her into these reverenced and honored limits [of marriage] came to her distinctly" (308).

Nan and Dr. Leslie both believe that marriage is a normal and admirable ambition for both men and woman—but again, the characters reflect the popular belief that not all people will, or can, marry. Such individuals must recognize that they have been intended to serve their communities in some other way; the more such individuals accept this destiny, the more opportunity will be opened up to everyone: "It must be recognized that certain qualities are required for married, even domestic life, which all women do not possess; but instead of attributing this to the disintegration of society, it must be acknowledged to belong to its progress" (332). For Nan, professional life is incompatible with the traditional role of wife, but it is eminently well suited for the essential, feminine role of mother—only in her case, she has the power to care for many, rather than simply a few:

> . . . when she remembered her perfect certainty that she was doing the right thing, and remembered what renown some women physicians had won, and the avenues of usefulness which lay open to her on every side, there was no real drawing back, but rather a proud certainty of her most womanly and respectable calling, and a reverent desire to make the best use possible of the gifts God had certainly not made a mistake in giving her. "If he meant I should be a doctor," the girl told herself, "the best thing I can do is to try to be a good one." (193)

As a result, the realities of external, economic competition are irrelevant, and the internal competition between conflicting feminine roles is easily resolved by lifting her above the either/or dilemma to find an exemplary, irreproachable solution; she is elevated far above any need to have her femininity validated through marriage to any mere man, becoming instead a kind of secular bride of Christ:

> . . . it was a great pleasure to belong to the dear old town, to come home to it with her new treasures, so much richer than she had gone away that beside medicines and bandages and lessons in general hygiene for the physical ails of her patients, she could often be a tonic to the mind and soul; since she was trying to be good, go about doing good in Christ's name to the halt and maimed and blind in spiritual things. (342)

Similarly, G.G. Alexander's *Dr. Victoria* (1881) is also excused from the demands of the romance plot by a higher, more spiritual vocation. While her foster sister and two half-sisters participate in the trials and tribulations of romance, eventually marrying and having children, Victoria ends up by devoting herself to increasing her powers to help and heal. But unlike Dr. Janet and Rhoda Gale, Dr. Victoria is not placed by the narrative in this position of celibacy because of a lack of feminine characteristics. On the contrary, not only does she possess her share of ordinary femininity—Victoria likes to dress well and do needlework—she surpasses it. Victoria is set up for the readers not as the *New* Woman, but as a New *Woman*—not an unsexed virago, but a noble, saintly, essential Woman, whose celibacy is only part of her transcendent perfection of the idealized female virtues of compassion and maternal nurturance. Like Nan Prince, she knows that she can best accomplish her mission of womanly service by dedicating herself spiritually to all, rather than binding herself heterosexually to just one.

Prevented from marrying because of her illegitimate status, she soothes her broken heart by turning her emotional energies first to nursing, then medicine. But unlike the hapless Dr. Breen, Victoria is ready to make something of her educational experiences. Rather than "brooding over the revelations of a past which had cast its broad shadows over her whole life" (Alexander, II, 243), she is able to rise above her own personal pain to bring relief to others:

> . . . after years of striving, she had conquered self, and had a goal in life—something to work towards—beyond the mere gratification of sense, or the advancement of her own interests. She had extended her sympathies; and she seemed cold, only, because her love was spread over a wide surface—cold as the rays of the sun may be called cold when compared with the blaze from a furnace fire (II, 242).

Victoria's medical education takes place largely behind the scenes, with Victoria herself studying alone in Europe. Her absence from the daily lives of her family and friends is comparable to a nun's seclusion behind convent walls. And as the above quote demonstrates, it does seem that Victoria has spent her years of study in a struggle that is as much spiritual and psychological as it is professional: her studies are vocational in more than one sense of the word. Victoria is studying to be a doctor—a secular occupation which demands a combination of technical and business skills. But there is no mention of material ambition for Victoria; like a nun, she has pursued her vocation out of a desire to minister to others' bodies and souls, rather than to gain either money or status for herself. Consequently, although her education gives her enormous power, she is incapable of using it to diminish the power of anyone else. The knowledge and wisdom she gains as a result of her educational experiences casts her in the role of confessor and hierophant for all the other characters in the story, who love her as a friend and sister, and do not fear her:

> . . . Victoria spoke with all the force and authority which belongs to deep convictions based on knowledge; for let fools scoff if they will; knowledge is a power, and it is he who unites a strong mind to a soft heart who is best able to lend a helping hand to the feeble and the frail. For the weak love those best who can give them that which they want most—strength. It was this power that caused equally the disappointed lover, the bereaved wife and mother, and the saddened and afflicted child, to seek for consolation and comfort from Victoria. (III, 166-67)

In the end, her near superhuman learning enables her to work miracles, and restore sight to her poor, abused cousin, whose guardian she becomes—making Victoria, in the end, a saint-like Virgin Mother who washes away the sin and sorrows of all who seek her out: "They saw not what Victoria saw, the bright blue sky [behind the dark cloud of blindness and suffering]. They knew not, as Victoria was learning to know, how to roll back that cloud of darkness and say, 'Let there be light'" (III, 174). In this novel, then, the woman doctor is by no means a threat to middle class domestic ideology—to female domestic interests, or male economic concerns. Rather, she is its ultimate product, the epitome of essential female purity of mind and body, dedicated to the service of others. Thus, while Victoria does not find romance for herself, she still participates with the other characters in the achievement of its goal: the propagation of middle-class values and ideals through the medium of the novel.

Medical Women Learn and Teach Their Way to a Resolution

Finally, the third narrative pattern is one which reflects a greater willingness on the part of the authors to modify the romance form to accommodate more flexible, and thus more realistic solutions to the problem of the medical woman. The outcomes for the women doctors in this group are all designed to teach readers that, in the view of their authors, the choice between traditional and reformed roles for women need not be either/or, a competition between work and personal life where the only solutions are love or a celibate career. These novels acknowledge that while the dilemma for the professional woman is more complicated than that, its very complexity allows for a greater variety of satisfying resolutions. The novels are the testing grounds for the solutions, showing, in fiction, the imaginative outcomes available for the non-fictional world. To make these outcomes plausible, the novels are also willing to represent the conflict of the female protagonist as less exclusively internal, and so as more realistic. The medical women in these narratives do have choices to make. But in their cases, the basic competition does not take place only within: they must also deal with conflicting forces without—including male competition, in order to show that the conflicts faced by the woman doctor have as much to do with the competing values and expectations of others in society as they do with her alone. The choice between personal life and career is not just an issue of the woman's own sense of identity—particularly the sense of her own fulfillment as a "natural," womanly woman—but is also shown to be greatly affected by how others see her, especially men, including her male competitors.

To demonstrate this, I would like to concentrate first on one case study, Anne Elliot's *Dr. Edith Romney*, published in three volumes in 1883. When we first meet Dr. Romney she is a great success in the manufacturing town where she has hung out her shingle. The social-climbing, nouveau-riche manufacturing families are all eager to exploit Edith's social cachet as being both "modern" and slightly beyond the pale. But she has made an enemy by attracting patients away from the town's woman-hating Dr. Fullagher—old-fashioned, out of fashion, and on the verge of retirement. Out of spite, he encourages his protégé, Dr. Fane, to compete aggressively with Edith for patients—and Fane wins. By the end of Volume II, Edith is running out of money, and is suffering badly from depression and growing physical weakness. It is only at this point, however, that Fane actually meets his competitor—and once he sees that she is young and beautiful, and not the old virago that he had expected, he starts to fall head over heels in love, and bitterly regrets his previous treatment of her. After Edith nearly dies from a seemingly inevitable bout of brain fever, both Drs. Fullagher and Fane repent and come to see their competitor in a new light. Dr. Fullagher lines up a new job for Edith in another town, and Fane, conveniently set free from an engagement to a more conventional girl, ends the novel by begging Edith for her permission to try to win her love.[10]

The conflicts of the novel work on two levels. On the one hand, it is a romance, where two unlikely lovers are drawn together in spite of various social obstacles. On the other hand, it is more than a typical romance, with its drive towards reinforcing middle-class, capitalist, patriarchal ideals. Instead, the novel is a very deliberate case study of the new problems facing the New Woman of the late nineteenth century, as she sought to redefine terms such as respect, success, and femininity. Edith, like so many other women pioneers of her day, does not see herself as a radical, seeking to overthrow middle-class domestic ideology altogether; nor does she have any desire to live outside of ideology, isolated but comforted by the truth of her convictions. Rather, her problem, and the problem of the novel, is how to find a means of compromise, to alter middle-class ideology, to modify it—but not destroy it; to create a new concept of female professionalization and authority that brings the domestic to the public, making it seem natural, and thus acceptable.

Although they may result in very different outcomes, all of the other doctress novels also deal with this same problem. But while most of them are focussed on finding a solution for their women doctors, *Dr. Edith Romney* is unique in that it does not provide any neat answers or clear resolutions; instead, the novel focusses on teaching both its central characters, and its readers, crucial lessons about the *nature* of the problem itself. That is, the other novels have a tendency to reduce the medical woman's situation to operating solely and simply on the level of the personal, in relative isolation from the larger network of social, political and economic relationships that would affect real individuals. *Dr. Edith Romney* is one of the few doctress novels that—sentiment and romance aside—actually attempts to move beyond essentialist thinking, and instead places the medical woman in a more realistic setting. Edith's story is not fuelled by the relentless drive towards a happy ending. Rather, the focus is on the narrative conflicts themselves, as Edith experiences the complexity of trying to be both a person and a figure of authority in an environment where the individual's power over her social and economic relationships with others is limited, and often at the mercy of forces beyond her control.

Although many of Edith's difficulties centre on conflicts of class and status, sex is, without a doubt, at the root of many of the evils which beset her. Edith is a female in a society rigidly divided by gender, and so it is almost impossible for Edith's patients to conceptualize how she could possibly do anything to cross gender lines. And yet, her profession gives her the normally masculine rights to go about freely, to mingle between classes and genders, to give orders, to charge and collect fees, and to give opinions. Such privileges are met with bafflement, and eventually resentment and punishment, on the part of both men and women. The men feel that their privileges are being usurped by an interloper, and Edith is alienated from other women because they have no training in relating to a creature whose experiences and education are so different from their own.

But despite the fact that Edith's education has taken her so far away from many of the women she knows, she does nevertheless share their basic training in femininity. She is, at her core, a lady; and while this is to her advantage to a degree—if she cannot command respect based on her professional credentials, she can invoke class—it also works against her. As a lady, she has been educated to scorn such hard-headed business tactics as flattery; she has been taught to be noble, idealistic—in other words, naive. Lacking the kind of pragmatic or worldly knowledge that might be part of a man's education, Edith doesn't know how to "manage" her patients.

> More than professional qualifications were needed, more than the readiness and power to work, and this something more was a knack of management, which Edith had till now despised and never needed, but which she was beginning with some disgust to find, would be perhaps necessary after all, when competition pressed her harder. (I, 166)

That is, instead of humouring her patients in their fancies, or "stroking them into a complacent certainty of their own importance" (I, 195), she treats them with what she believes is a more professional degree of common sense and directness: "she had earnestly insisted on reforms in diet and exercise, little dreaming how unpalatable the advice was, and how gradually and surely it was offending her patient" (I, 195). Fane, on the other hand, has no scruples about using charm to sway his clients, and his superior management, rather than superior doctoring, is what wins patients away from his competitor.

Edith's failed approach to managing her patients suggests that she, like many readers, tends to assume that her gender is the only problem she has to overcome, and that it is only *her* problem: if she can just prove that she is as skilled, professional, and unsentimental as any male doctor, prejudice should crumble before her. But as Fane's example demonstrates, the prejudice Edith faces is not just a matter of gender; or rather, the problem of sexism is complicated by factors other than sex. In fact, this prejudice has as much to do with how Edith's patients' perception of her is affected by their own desires for symbolic capital—status, popularity, approval, and respect—as it does with how she presents herself—as a woman, as a doctor, or as a combination of the two. Edith initially chalks her early successes up to her patients' rational and sensible recognition of her skills. But as her own status and reputation crumble throughout the novel, she realizes that her professional credibility does not rely on her skill as an objective quality, but rather, on the irrational, insensitive, and subjective motives of others. The largest obstacle facing the pioneering medical woman is not conscious and directed enmity, but the cumulative effect of unconscious and diffuse ignorance and selfishness.

For example, Edith is shown, first of all, to be the victim of fashion—she is "picked up" by the town's trend-setting women, and once Fane comes along, she is as quickly dropped. This leads to her being the victim of others' conformity—once the trend-setters set the trend against her, everyone else follows to maintain his or her own popularity. Then, once she is no longer fashionable, her patients start to realize how little social function she serves. Aside from the fact that she is shown to be an excellent doctor, she offers her patients nothing in the way of improved social status. As a working woman, she is of course unsuited to marry the sons of socially-conscious families, unlike Fane, whose flirtatious charm gives every matron the hope of marrying off her daughters to a gentleman. The resulting prejudice against Edith persists throughout the novel because it is based on ignorance and narrow-minded acceptance of social conventions, both of which prove impervious to reason:

> It maddened [Fane] to think that the noble, strong, beautiful woman he adored should be criticized and held cheaply by every feather-brained individual like the one before him—that it should be necessary to her content that creatures such as this, vapid, commonplace and narrow, should believe she was capable of what she professed; and that, prove her ability by word and deed as clearly as possible, no proof would shake the obstinacy of their sublime stupidity. (II, 296-97)

But while such behaviour is condemned, its persistence is also proof of the near-impossibility of overcoming it. For example, even though Fane is gradually converted to Edith's side (he falls in love with her anyway), his endorsement comes too late, and she is still faced with the necessity of relocating if she wishes to begin her practice again.

The prejudice against Edith is further fuelled by the two male doctors' plot to ruin her practice. But it is important to realize that their initial hostility towards her is not, as they joke themselves, based on simple "woman-hating": the two doctors are no better than the rest of the town when it comes to questions of status and class. Certainly both Fullagher and Fane object to women doctors on the basis of their being unnatural and unfeminine:

> "Dr. Romney is not the son, but the daughter, of Hugh Romney."
>
> "The devil!" exclaimed Fane . . .
>
> "No, worse," said Fullagher, nodding gently—"a woman."
>
> "A lady-doctor in Wanningster?—and successful?" said Fane in slow amazement. "Why, the people must be crazy! . . . I think they are monstrosities!—everything that is unwomanly and odious! I cannot bear to think of a woman stepping out of her proper sphere and thrusting herself into strife with men. It is degrading to her."
>
> "Quite so. I agree with you entirely."
>
> "And you mean to say that this—this woman has positively taken your practice from you—*you*, the oldest doctor in the town?"
>
> "The women and children, certainly—the best of one's practice." (I, 11)

As products of their time and class, they cannot easily conceive of the idea of a woman being a lady—the repository of middle-class ideals and the symbol of social stratification and status—while at the same time possessing the kind of privileged knowledge and experiences essential to the construction of masculinity. Nevertheless, such woman hating is rather superficial, especially when they are faced with a beautiful woman, and would no doubt remain at the level of a joke, if it were not compounded by an equally alarming threat posed by Edith. That is, she's no lady, she's the competition. The problem is not that a *woman* has stolen Fullagher's practice; it is rather that a woman *has stolen his practice*. The motive for the men's attack, then, is at bottom economic, and to overlook this motivation is to misunderstand, or to underestimate, the complexity of the hostility directed towards women professionals—women workers of all kinds—in the late nineteenth century. Female professional authority is a threat to sexual power, but it is just as much, if not more, of a threat to basic economic power and—in a community where money is increasingly as much of an influence as breeding—social status.

Thus Dr. Fullagher's vendetta against Edith acts out the same hysterical response adopted by the male medical profession as it attempted to maintain its monopolistic grip on the market in the second half of the nineteenth century. As we have seen, this consolidating strategy was directed against all competitors existing outside the medical mainstream—including women and men—and depended on the exploitation of privileges already commanded by male professionals in other fields: the power to determine wages and earnings (and thus control supply and demand); the power to create a monopoly by controlling education and credentials—and discrediting would-be competitors; and the power to network. And this is the point where sex and economics combine into an obstacle greater than the sum of its parts, as Edith finds—as many other women pioneers did then, and as many women still do today—that she is at the greatest disadvantage in business because of her gender. Her patients do not believe that her training is as reliable as a man's, and they do not believe in equal pay for equal work:

> ". . . Seems queer for a lady to charge as much as a h'ordinary doctor—deuced queer, by Jove! Why, if that's to be the little game, we may as well 'ave the real h'article at once . . . all female labour is inferior in the market—"

> "If you thought so," interrupted Edith . . . "I wonder you would risk the health of your wife and daughters!"
>
> "Why," cried Mr. Chutterworth, "there wasn't no risk. They've never ailed nothing but fancies these last six months! Of course . . . if there'd been something serious got 'old of one of 'em such as—well, say fever or—or—well, *h'anything* dangerous, it would have been another bale of goods altogether . . . You don't suppose I pay my female 'ands what I pay the men? By the powers, no!—nor no manufacturer don't! That's market law, Miss Romney, women's work is cheaper than men's. Stands to common-sense it must be so. A pretty state of things it would be to have women taking the work and pay from men!" (I, 273-4)

Moreover, and perhaps just as damaging to Edith's career, she has neither the opportunity, nor the training to network. She is prohibited by her lady-like upbringing from mingling too freely with men (she cannot, after all, stay on at the table to drink and smoke after the ladies have withdrawn), and, as I mentioned already, her charms do nothing to create bonds with women, who have themselves been trained to respond more directly to the flirting of men.

So Fullagher and Fane succeed in ruining Edith's practice—her economic autonomy—and her health. And, if the aim of this novel were to prove the fundamental impropriety or futility of women's claim to professional authority, it would stop here. But instead, Edith recovers her health, and with it a new sense of hope and purpose, as well as a new and significant sense of herself. At the beginning of the novel, she sees herself as an individual who must be judged on her own merits, and whose talents will speak for themselves apart from class and gender. By the end of the novel, she has come to understand "the full significance of her unusual choice . . . it was not the simple personal matter it had appeared" (II, 34). That is, Edith has come to the crucial realization that she is not simply an individual, she is only part of a society bound by an ideology that asserts hegemony over its members through convention and prejudice. Moreover, she learns that she is part of the social sub-category of Woman, which imposes special restrictions on the possibilities and potential she can expect from her life in society. Finally, and most importantly, she realizes that, as a woman who is also a doctor and a professional, and not simply the embodiment of social expectations, she also has a right, and an obligation, to place herself in the category of feminist. By the end of the novel, when she is not occupied by falling in love with Fane, she expresses new, firm thoughts on the issue of women's rights to education and social and economic independence:

> "I see," said the doctor, nodding his head deprecatingly; "I see. You do go in for women's rights. I fancied you did not."
>
> "Yes," said Edith, firmly and gently. "I do now. I did not think or care about the question at first, but I have been obliged to do so. I have thought a great deal on the subject lately, and I see that our lot is a hard one—hard by nature, because we are physically weaker, and trebly hard on account of the burdens and restrictions put upon us by custom." (III, 165-66)

This new awareness of her place in a larger, complex network of social relations also teaches both Edith and the readers something new about the possibilities for the construction of female professional authority. *Dr. Edith Romney* makes it clear that this professional authority *is* possible, and that it can only begin within the woman herself, through skill and education, but more importantly, through self-confidence. There is no chance of others placing their faith in her, if the woman cannot do as much for herself first. Edith regains this self-confidence at the end of the novel, and she faces the prospect of both professional and personal happiness. But while this seems to leave the readers with a positive image of the female professional, there is still uncertainty; the optimism of the happy ending is tinged with the beginnings of new potential difficulties. Yes, she has a new job to look forward to, and the man she loves is on his knees before her—but what will happen next?

The novel refuses the closure of the happily-ever-after marriage plot, with its tendency to solve all of the female protagonist's problems by subsuming her within marriage—and leaves instead just possibility, a space for the readers to fill in. If we have been completely persuaded by the novel of the fitness of women for professional authority, we will finish the story by allowing Edith to have it all—career, family, the love of a good man—but if we have any doubts, we may finish it differently. After all, the novel makes it quite clear just how difficult it is for a woman to go against the plot that society, and ideology, have written for her. Edith's example reminds us that the personal is indeed political—but that change in the political does not happen at the personal, individual level alone. The fact that the novel underscores this dilemma with its ambiguous conclusion makes Dr. Edith Romney an apt representation of the steady, but frustratingly slow struggle for women's rights since the late nineteenth century. Edith's transformed sense of self suggests cause for hope, but we are also left with the nagging suspicion that there can be no satisfying, happy ending as long as that same transformation eludes so many other individuals—both male and female—in the society around her.

In a way, then, the novel is as much about what other characters—and readers—learn about the value of women's rights over the course of the narrative as it is about the development of the central character. Edith learns important lessons about her own abilities, her place in society, and her commitment to revising her role within society. But perhaps equally importantly, her struggle also serves as an illustrative lesson to others—namely, the men in her life, Fullagher and Fane—about the nature and consequences of mindless prejudice and unfair social and economic practices. Through the education of Fullagher and Fane in particular, the readers are also educated, learning by doing as they become involved in a process of consciousness-raising in regard to the Woman Question. By the end of the novel, Fullagher still has his old-fashioned doubts about women professionals, but Fane finds that his own abstract political convictions fall apart when confronted with the concrete reality that they hurt the woman he loves.

And it is this particular re-education of the male love interest that seems to be the most crucial starting point for the woman hoping to resolve the conflicting demands of the personal and political. There is a way to achieve compromise, for the woman to have it all, this novel suggests, if only she can find others who share her viewpoint; and the most important other in this case has to be the opposing figure in the complementary, binary universe of domestic fiction, and domestic ideology—the potential husband. If this figure can accept a modification of the woman's role, thus accepting some modification of the significance of his own role, then the threat that female emancipation poses to romance, and to middle class values, is neutralized.[11]

As the other doctress novels in this third and final category demonstrate, this new, reformed relationship is flexible enough to fit the needs of a variety of professional women. Involvement with men need not be only adversarial, whether economically or romantically; and cooperation, rather than competition, is an achievable goal. For example, Margaret Todd's *Mona Maclean, Medical Student* (1896), presents a vision of medical school and practice where men and women can come together as friends, rather than rivals—a far cry from Rhoda Gale's experience of hostile rivalry. In fact, Mona is fortunate enough to live in slightly more enlightened times when some of the problems of women's medical education had been solved by creating separate women's schools affiliated with the men's. Mona actually studies almost exclusively with women, and her failure to pass her exams on more than one occasion is portrayed less as a matter of competition with men, and more as a matter of her inability to buckle down and live up to the same sense of commitment exhibited by some of her female classmates who possess a stronger sense of identity: "Miss Maclean sees things very quickly, and she sees them in a sense exactly. She puts the nails in their right places, so to speak, and gives them a rap with the hammer; she fits in a great many more than there is any necessity for, but she does not drive them home" (Todd, 367).

Competition with men for business or status is decidedly not a conflict for the medical women in this novel; indeed, it seems to be one strategy of the novel to show readers just how acceptable the medical woman can be by showing other medical men so willing to take her right to study and practise as a given. When Mona takes her last stab at her exams near the end of the novel, she is in competition with her would-be love-interest, Dudley. But it is part of the novel's overall plan to establish their romantic relationship on an equal and progressive footing that no doubt accounts for the fact that Mona and Dudley both graduate with nearly identical honours. Dudley never comes into conflict with Mona over her right to practise—he is, from the beginning, a model of the New Man who is secure enough to be able to accept and appreciate an equally skilled and educated female companion. Not only does Dudley not pose any obstacles of male chauvinism for Mona, he actually serves to facilitate her return to medical studies. When he puts his trust in her to help an unwed mother, he gives Mona a chance to remember the goals of service and care that she had nearly forgotten about amidst the pressure to pass her exams.

That they both then go on to practise medicine together out of the same home office further demonstrates the novel's vision of the ideal, modern "Fin-de-Siècle Courtship" (461). They turn down Sir Douglas' offer of a prestigious and comfortable Harley Street practice, preferring the excitement of late night calls, and the rewards of working among the less fortunate. And in their practice, as in their relationship, they exemplify the novel's enlightened version of complementarity; the sexes are equal, but different, each able to do the same work, while also making the best use of each sex's unique qualities. According to the proposals made by real medical women, the male patients are left to the male doctor, while the female patients will come under the physical and moral care of the female professional:

> . . . a young girl entered the room with a shrinking, uncertain step. Her hair was wet with the rain, and her white face expressionless, save for its misery.

> "Do you wish to consult me?" [Dudley] said. "Sit down. What can I do for you?"
>
> "She looked at him for a moment and tried to speak, but her full lips quivered, and she burst into hysterical tears.
>
> His practised eye ran over her figure half unconsciously.
>
> "I think," he said kindly, "you would rather see the doctor who shares my practice," and he rose, and opened the door.
>
> Mona looked up smiling.
>
> She was sitting alone in the firelight, and his heart glowed within him as he contrasted her bright, strong, womanly face with—that other.
>
> "Mona, dear," he said quietly, "here is a case for *you* . . . ." (474)

Mona and Dudley are equally well educated, equally competent and dedicated to shared, noble goals, equally confident in their own identities and their love for one another—so that competition or unhealthy rivalry has no place in their relationship.

While Mona is lucky enough to find a man already pre-disposed to accept the modern marriage of equals, other women doctors find, with Edith Romney, that most good men are made, not born. *Helen Brent* (Annie Nathan Meyer, 1892) is one such medical woman, who discovers the necessity of re-educating the male love interest as the only way of bringing balance to the male-female dichotomy of domestic ideology. The novel is a transparently propagandistic work, where the romance plot is engineered to serve the larger interests of Meyer's views on marriage, as espoused by Helen.

The novel quickly establishes Helen's ability to combine irreproachable womanliness with a "masculine" career; and her competence for both work and romance is not questioned. Although the medical woman is the central character of the novel, the narrative is not dedicated to exploring her development; Helen does not change, because she does not need to. Rather, the novel documents the gradual transformation of Harold, her would-be suitor, from conventional and narrow-minded to reformed and enlightened—an educative process directed and elucidated by Helen for both Harold's benefit and the reader's. Because the masculine and feminine spheres define each other by their opposition, the novel insists that a change in one must involve a change in the other. Whether that change takes place in the real-life realm of economic competition and co-operation, or in the fictional realm of romantic tension, the developments of the female half of the equation must be paralleled by similar advances on the part of the male: " . . . marriage must be a state of higher duties to both man and woman; it is only when both sexes understand the responsibility which rests on each, it is only then that marriage can be truly ideal" (181).

As Helen argues, these advances towards both male and female emancipation do not by any means threaten middle-class values, especially the emphasis on the family as a model of economic and social relations. In fact, freeing husband and wife from the demands of fashion and convention would tend to improve the state of marriage and the family rather than damage it. As Helen's friends, the Dunnings, demonstrate, a marriage where both partners work and look after one another provides far more economic comfort and personal satisfaction, for each partner equally, than would be possible in a traditional marriage where the husband is always absent, and the wife is bound to husband and child as a glorified drudge, or a pampered ornament.

Helen believes in the necessity of both husband and wife honouring the division of duty in order to make the family work, and would not suggest that female career interests be allowed to interfere with a woman's obligations towards her husband and children. But to Helen, the primacy of family stability is threatened not by the professional woman, but rather, by the professional man. If both husband and wife agree that they must work to maintain their middle-class family, the husband must also honour his obligations, by not allowing his work to interfere with the time he spends at home. If husbands did not neglect their families—as Harold Skidmore neglects his in order to pursue his political ambitions—and allowed their wives the same opportunities for self-improvement they insist on for themselves, wives would be able to pursue activities that enriched them as individuals, making them better companions and parents.

Helen does believe that many women need to take greater responsibility for their lot in life: the majority of the women Helen sees at society teas, or in her consulting room, thoughtlessly accept the status quo, and perpetuate it in their education of their daughters. She hears many women complaining about the demands of being middle-class wives—the exhausting whirl of society functions, trying to get daughters suitably married off to husbands who will neglect them as much as the fathers do the mothers—but she is frustrated and depressed by how few women are willing to break out of their complacency:

> Women have lived so long in such a narrow sphere that their judgement is warped. They have become conservative through seeing only one phase of life; only one kind of existence going on. Men, on the contrary, through rubbing up against many men and women, through so many phases of life, so many types of people, often acquire a breadth, even the most ordinary, uneducated men, which is not possessed by any but an exceptionally broad-minded woman. (102-3)

As many other fictional women doctors discover, prejudice and narrow-mindedness are not confined to only one sex; hence, in Helen's view, all the more need for women's emancipation. Education and work can only improve women as useful members of society and contributing members of their households. Nevertheless, Helen sees that her fellow nineteenth-century women are changing; and the real problem lies with men's apparent inability and unwillingness to keep pace:

> No, there was absolutely nothing for women to do to help on the solution of this great problem of marriage. The change must come from men. They must be educated to allow greater liberty of thought and action in their wives, to seek in them companionship in marriage, to seek sympathetic co-

> operation, not merely physical gratification, over the mere oiling of the household machinery. (54)

Skidmore's inability to understand that Helen's progressive views would only improve marriage, not threaten it, keeps them apart for the whole of the novel. He is convinced that her medical career would make it impossible for her to attend to the needs of a family, especially his own; and so he gives up on his relationship with her, instead marrying a more conventional and idle woman who seems better suited to his ideals. Helen sees his marriage collapsing long before he does, for exactly the reasons she predicted. Skidmore completely neglects his wife in order to pursue his work, being married more in name than in fact. Without a vocation of her own, Mrs. Skidmore has nothing to stimulate or occupy her—until she begins an affair with a known debauchee.

It is only when Skidmore is almost totally destroyed by his wife's affair, illegitimate pregnancy, illness (of the venereal variety), and divorce, that he begins to realize the essential truth of what Helen has known all along. A happy marriage does indeed require a womanly woman to be the companion to her manly husband, and not his competitor; but the man who seeks such a companion in a woman lacking education, principles, and commitment will always be disappointed. A woman's dedication to some higher good outside of herself does not pose a threat to successful gender relations; her activities will not compete unfavourably either with her family obligations, or her husband's obligations to both home and career. Instead, such a dedication is in fact both the proof, and the practice, of a woman's essential femininity, as the more she cares for others, through an appropriate choice of career, the more capable she is of caring for those closest to her:

> . . . if . . . I am to give up my whole professional ambition, my sense of what I owe it and the world, if I am to sink my whole existence into being your wife, I shall feel degraded. I shall feel as much so as if I had lost the respect of the world. It would mean to me the victory of passion over

> reason, of my inclinations over my sense of duty. If I could honestly bring myself to believe that a woman's proper field is marriage, and that every other object in life ought to be waived for that, it would be easy for me. But I cannot. I have accomplished enough in my work to justify me in feeling that I have a mission, a duty to perform; to give this all up for you is to myself fall utterly in my eyes, and I could never be happy without the respect of my own self. To me it is more important than the respect of all the world. (39-40)

At the end of the novel, Skidmore finds that his once-inviolable notions about marriage and career have led him to nothing but isolation and misery. Chastened and humbled, he writes Helen to beg her to take him back, on her own terms. The novel does not provide Helen's answer, and we are left to guess at possibilities. On the one hand, if Harold has not truly reformed, then perhaps, the novel suggests, the professional woman will have no choice but to carry on unmarried, with hope for satisfaction in work, but none in marriage. The price to pay for leading other women into a more progressive era may be relative solitude along the way. On the other hand, that an equal and satisfying relationship can emerge out of the utter defeat of one party may seem doubtful; yet Skidmore's chastisement and repentance seem to be necessary in order to completely purge him of any lingering and pernicious susceptibilities to the far more damaging influence of male arrogance and social conformity.

By contrast, Major Dick North—the would-be romantic hero of Hilda Gregg's *Peace with Honour* (1897)—is spared most of Skidmore's suffering, even though he also must undergo a similarly difficult process of re-education. Although he is deeply attracted to Dr. Georgia Keeling, he is unable to contemplate a relationship with a woman who insists on practising what he sees as an unwomanly profession: "It ought to be made penal for any woman to enter any trade or profession practised by men . . . It makes me perfectly sick to see these women parading their independence of men, and glorying in what they know, and ought never to have learnt" (Gregg, 46-47). Georgia, as one of two doctors in the mission to Khemistan, does not threaten to compete, or interfere professionally with, North, the soldier. But Georgia does pose a challenge to North's belief in the male prerogative to organize social roles, both male and female. North has exercised this prerogative to decide that women like Georgia—ladies—are guardians of virtue and morality, whose duty is to preserve British civilization in the home. It is the job of gentlemen like North to protect the Empire by protecting the home, and that means keeping the home, and the ladies within it, far removed from the dangers of the great wide world.

Georgia's presence in his trade mission to Ethiopia, and her disregard for his beliefs about gender roles, upset all North's notions about the order of the world. Georgia does not consent easily to being protected, and chooses not only to protect herself, but to do her duty to protect others as well. She makes dangerous journeys to care for sick village women; she ventures into the corrupt world of harem politics in order to save discarded wives and children, and, by her example, shed the light of British morality and honour. But to North, any results she achieves are lucky accidents, accomplished only at the cost of his peace of mind, because she has acted against his better judgement.

Nevertheless, North falls in love with Georgia anyway, and she is inclined to return his affections, except that neither can overcome the fact that he cannot envision married life with a woman who works. Georgia tries to explain to him that she cannot, in good conscience, give up work as long as she is in the unique position of being able to help those who might not otherwise have access to any medical care. And as much as she loves him, she knows that as long as he is unable to understand her point of view, they can never have a future:

> . . . she was . . . aware that any surrender on her part would only bring her grief and remorse later, and she longed to be able to do something that might justify her in Dick's eyes, might bring him to acquiesce of his own free will in her continuing the practice of her profession, and thus avert the

> crisis she foresaw and feared. There was only one thing that could come between Dick and herself, and that was her work; but she knew that if she was true to her principles, she must uphold it against Dick. (260-1)

As is the case with *Helen Brent*, the medical woman's belief in, and respect for, her own professional competence is never in question. She is secure enough, as both womanly woman and skilled doctor, that her sense of purpose cannot be shaken by a skeptical man. Her maturity and steadfastness, compared to North's childish obstinacy, serve to represent her as a paragon, a role model to readers. And yet, there is distressed regret on her part: the New medical woman is not so radical that she would *willingly* choose to be single rather than find a way to make a romantic relationship work. Georgia is willing to compromise; but she, like Helen, finds that the problem lies not with her, but with the hide-bound man. The whole trade mission eventually becomes convinced of the fitness of Georgia's vocation, but North is a stubborn, and miserable, hold-out, insensible even to the irreproachable logic of the very womanly Lady Haigh:

> "Oh, Lady Haigh, tell me what to do. How can I begin to make things right?"
>
> "Put yourself in her place. Would you like it if she expected you to give up your military career for her sake?"
>
> "She would never ask or expect such a thing. She knows that I could not do it, even to please her."
>
> "Then return the compliment. She is willing to give up for your sake any hope of distinguishing herself further in her profession by means of original research, but she will not relinquish the practice of it. Allow her the freedom you claim for yourself—in fact you must allow it, if you mean to marry Georgia Keeling. She will be yours heart and soul, but a certain portion of her time and interest she will always give to her work."

> "But come now, Lady Haigh, doesn't that strike you as slightly rough on a man?"
>
> "It strikes me as merely just," snapped Lady Haigh. "No portion of your time and interest will ever be given to your work, of course?"
>
> "Oh, but that's different, you know," said Dick, uncomfortably. (396-97)

Unfortunately, words alone have little effect on North—it is only once Georgia has acted with undeniable courage and womanly self-sacrifice to save her comrades that North is led to change his mind. When Georgia's role as doctor allows her to gather crucial information about the trade mission's enemies, as well as the antidote to a particular poison, she helps to save both the mission and its leader—and the fact that the mission could not have survived without Georgia's help is not lost on North. She has worked hard, and risked much in order to prove herself to the group; North may have deep prejudices, but ultimately they cannot overcome his instinctive Englishman's response to Georgia's appeal for sportsmanship and fair-play. Just as the diplomatic mission nobly achieves the virtuous, English goal of "peace with honour," so too do Georgia and North: he grudgingly concedes that his stereotyped views of women, and the impropriety of women taking on professional roles, were misguided. He has learned—been instructed—that the true measure of a woman's feminine character is her ability to stand up to all challenges with strength and nobility, rather than cowering meekly before them, and leaning passively on the arm of some male protector. North realizes the merits of being involved with a companion who can share in his imperialistic efforts to conquer and lead in the colonies. In the end, they marry: Georgia continues to practise medicine on the frontier with him, tending to the native women and children, and winning them over by example, while he maintains order through sound British diplomacy and force.

Although far removed from the adventure-romance setting of *Peace with Honour,* Maxwell Gray's *Sweethearts and Friends* (1897), follows a similar narrative pattern; again, the male protagonist (Vivian Lester in this case) experiences first-hand the instructive effects of female example on male prejudice. Like Helen and Georgia, Dr. Amy Langton is portrayed in many ways as a finished character; early on in the novel, her personality and motivations are defined, and the rest of the narrative is dedicated to tracking the changing responses of other characters around her. Amy settles on her medical career knowing that it involves sacrifice, but hoping that it will not demand complete romantic isolation: as a young girl contemplating medical school, she confesses, "I should not like men to hate me. I shouldn't like to be an old maid" (26). From her school days on, Amy's character improves, but does not waver; her unshakable ambition is to have both a career and a family of her own. Thus, the source of conflict in the narrative does not lie in her, but, true to the pattern, in the recalcitrant male: Amy's character is irreproachable and should not need to change; Lester's character is in much need of change, and yet reacts sluggishly to all potential catalysts. Amy can work actively to find professional success, but, as the narrative nears its end, she can only watch sadly, and with growing resignation, as romantic success, in the shape of Lester, seems to move out of reach: "She was very tired; the romance of daring an unusual life in the teeth of opposition had evaporated with the novelty of it, leaving a barren stretch of gray, uninviting duty behind . . . Amy had now no family life; she never could have one" (229).

Fortunately, however, Amy's influence is too strong to be ignored, and gradually the virtues of her character start to alter Lester's own. At the start of the novel, Lester, "the Immaculate," is at first shocked—though too much of a gentleman to show it—by Amy's seemingly unfeminine behaviour: her love of study, her commitment to medical work, and her unrestrained physical energy. When she manages to consume man-size portions of roast beef at dinner, Lester, "who liked ladies to dine on air and sentiment" (Gray, 8), is simply mortified. But as the story progresses, he begins to see Amy as being more natural in her enthusiastic development of the mental and physical talents she possesses than her romantic rival, Lettice, who uses her excessive femininity in unwholesome ways to manipulate and deceive. Lettice's moral decay eventually becomes so complete that she steals the fiancé of Amy's sister, and scandalously elopes; by sharp contrast, Amy only becomes more and more admirable, her abilities to help and heal compensating for any charges of a lapse in delicacy.

But despite Lester's growing love for and appreciation of Amy's noble and independent character, his old-fashioned, romantic ideals prevent him from relating naturally to the real woman:

> "Dear, I am no fit wife for you, I could not devote myself. I can not give up my profession. My interests would clash with yours. My profession—"
>
> "Ah! but Love is better. Try to love me, my own prophetess. If devotion, if love can make happiness, mine must make you happy, dearest."
>
> "Is happiness the best thing, or duty, Vivian?"
>
> "Love is both . . . " (235)

Amy insists on looking at their relationship rationally and pragmatically, while Lester unconsciously adopts the stereotypically feminine argument based in emotion—thus reproducing one of the essential conflicts played out by real medical women as they attempted to argue their case with logic versus their opponents' sentimental traditionalism. Lester frustrates Amy by his inability to see that what he regards as noble idealism is, in practice, confining prejudice. In the end however, Lester's sentiment does play a positive role: on the one hand, he has strong emotional attachments to his ideals of womanliness; on the other hand, he also has a strong investment in a certain ideal of manliness that includes both chivalry and sportsmanship. While Lester does allow his sentimental ideals about women to mislead him into a doomed relationship with Lettice, like North, he finds that he can modify those ideals, and change himself, if the greater appeal of fair play demands it.

Of course, Amy, like Georgia, has to work hard first to make the appeal sink in. At the end of the novel, when Lester attempts to save a child from a burning building, getting himself trapped in the process, it is Amy alone—out of a crowd of male onlookers and firefighters—who leaps forward with a cry of "For him or with him!"(247) to save him.

By this point, Lester, who has indeed undergone some maturing of character in the course of the novel, and who is wiser about women after his disappointment with Lettice, is not repelled by Amy's demonstration of heroism. On the contrary, he is manly enough to appreciate her courage as proof—rather than a denial—or her womanliness; moreover, sensible of his own standards of fair-play, he is also manly enough to admit that he has learned a lesson, and is ready to compromise: "I am not the hide-bound, prejudiced ass I was. Love has taught me better; a woman's love, a woman's heroism" (249). And what he has learned is that he has as much to gain from a marriage of equals as a woman does, since, as Amy's example has led him to see, it does not mean a loss of power, but a gain of greater trust, honesty, and beneficial interdependence:

> "Dear, I will never hinder you, only give me the privilege of helping."
>
> "Oh! but I am not the wife you need—not the helpmate," [Amy] faltered.
>
> "Just the wife, no other. As for obedience and helping, why not obey and help each other?" (249)

It could be argued that the reform and education of the male protagonist that is so essential for the doctress novel's happy romantic ending can come about only if it is also accompanied by a degree of feminization. I am arguing that Lester's willingness to make concessions is an expression of manliness, of strength and security; but the flip-side of concession is defeat, and a loss of power which might indicate a diminution of masculine authority. I doubt that the authors of the doctress novels would have deliberately risked the successful reception of their propagandistic message by potentially alienating those readers with a strong attachment to ideals of masculine authority. That a reading involving the loss of male power is possible is more probably an inadvertent result of an attempt to show the need for compromise and conciliation from both sides of the romantic and professional divide.

Whatever the intention, however, the possibility for a problematized or contradictory interpretation is there. But this should not be surprising: the doctress novels, like real medical women, were trying a difficult experiment. These novels aim to show how the medical woman could fit into the readers' familiar environment without disrupting it; and yet, of course, disruption is inevitable, since no matter how womanly, the doctress was taking possession of previously masculine territory. Real medical women were still attempting to make a place for themselves in a skeptical world, and no-one had a fool-proof blueprint for success. Similarly, while the experiment of portraying the medical woman in fiction enabled authors to assert happy endings, to prove that the doctress was not a threat, but a positive addition to society, it is only to be expected that any believable portrayal would also include a realistic measure of the authors' own, real-world, uncertainties, anxieties, and contradictions.

For example, Elizabeth Stuart Phelps' *Doctor Zay* (1882) is another novel that attempts to create a happy romantic ending for its doctress while falling prey to just the kind of inconsistency mentioned above. Once again, the successful narrative outcome hinges on the education and reform of the dubious male; but the ambiguous nature of the ending, which only hints at possible happiness, suggests that the author herself was unconvinced of the workability of her own experiment.

Dr. Zay—Zaidee Atalanta Lloyd—is not quite as physically impressive as Amy Langton, but she manages to over-awe—and educate—Waldo Yorke with her abilities nevertheless. The homeopathic Dr. Zay, in what is no doubt a deliberate contrast to Howells' Dr. Breen (see note 9), is a model of medical competence, and when Yorke nearly dies in a buggy accident, she is the one to bring him to safety, and see him through a long recovery. As Mesteller notes, their relationship plays with existing doctor-patient stereotypes, as Dr. Zay takes on the role of paternalistic, authoritative physician, with total control over the patient's moods and movements, and Yorke adopts the feminized role more commonly reserved for women—passive, weak, dependent, and emotionally fragile (138): "I am cherishing a host of feminine virtues . . . I shall make rather a superior woman by the time I get well" (Phelps, 134). But by bringing the man low in this way, the novel places him in a position where he is well suited to begin learning a new pattern for his relationships with women—or at least, with this particular woman—that challenges existing gender stereotypes: Yorke is cast as "a straw man whose shallowness and weakness highlight the strength and virtues of Dr. Zay . . . he is representative of Phelps's audience and with them is the object of her instruction" (Sartisky, 292).

Yorke comes quickly to admire Dr. Zay's patience, strength, and knowledge; and, more importantly, he sees them as expressions of her deeper feminine nature, rather than contraventions of it: "He experienced at moments a species of awe of this studious and instructed lady; not so much because of her learning, which was unquestionable, nor of her beautiful inborn fitness for the art of healing, which was as clear as the flash of her eye, as for the fact that, in spite of these circumstances, she could be a charming creature" (Phelps, 136). In turn, her depth of character and commitment to a noble goal inspires him with the desire to foster the same qualities in himself. Once he recovers, he finds that he no longer cares for a life of idleness and luxury, and takes up his neglected law career with a new, more manly energy.

Dr. Zay, with arguably a greater experience of the world, is the cautious realist, telling Yorke that he has "been so unfortunate as to become interested in a new kind of woman. The trouble is that a happy marriage with such a woman demands a new kind of man" (244). Dr. Zay's low expectations of the male species come as a challenge to him, and bring out the best in him, giving him a new force of personality, and the strength to be open-minded towards his unconventional love interest: "what kind of fellow should I be, if I could approach a woman like you, and propose to drink down her power and preciousness into my one little thirsty life,—absorb her, annihilate her,—and offer her nothing but myself in exchange for a freedom so fine, an influence so important, as yours?" (238). The qualities that make Dr. Zay an excellent physician make her an admirable woman, not a threat; and as such, she provides Yorke with the motive to become more of a man himself, to the extent that in the end it is he who must persuade her that their unconventional union could work.

In fact, as Masteller notes, Yorke conquers Dr. Zay's objections when she is at her weakest point in the novel, and so brings about a romantic resolution only through a disturbing parallel of the Atalanta myth after which Dr. Zay is named (Masteller, 140). On the one hand, Yorke has been taught to accept that Dr. Zay is most fully the woman he loves when she is both a woman and a doctor, and he does not, he says, wish her to give up her career. But on the other hand, his final proposal, and her acceptance of it, comes with the condition that she concede at least some authority to him:

> "This is not like simple happiness, such as comes to other people. It is a problem that we have undertaken,—so hard, so long! No light feeling can solve it; no caprice or selfishness can live before it. If we fail, we shall be the most miserable people that ever mistook a little attraction for a great love."
>
> "And if we succeed"—he began, unabashed by this alarming picture. She gave him one blinding look.
>
> "Come," said Yorke, passing his hand over his eyes. "You have had your way long enough. My turn has come. Hasn't it? Tell me!"
>
> "What do you want?" she asked humbly.
>
> "I don't want to feel as if I were taking a sort of—advantage. If you put me off one minute longer, I—shall. I shall take all I can get. I shall like to remember, all my life, that you came to me first, of your own accord; that you loved me so much, you would grant me this—little proof."
>
> He held out his arms.
>
> "Is *that* all?" she whispered. With a swift and splendid motion she glided across the little distance that lay between them. (258)

Readers can credit Yorke here with a desire to be equitable: on the one hand, he wants Dr. Zay to put aside her own prejudices—her fears that their experimental marriage will fail—and accept his optimism in the same way he has accepted her unconventionality; on the other hand, he does not want to pressure, or force, her into a decision. But he also demands that, in the end, she must come to him. It is important to remember that throughout much of the novel, Yorke has been positively at Dr. Zay's mercy, completely lacking in the physical or emotional strength to match hers; so if we are to accept Yorke as a suitable match for a paragon of womanliness like Dr. Zay, he must regain some power in the end—this is a small concession for her to make, and after all, he holds out his arms to her first. However, it is possible to make a less forgiving reading, and insist that this one concession of Dr. Zay's signals the beginning of the end for her claim to equality in the relationship, and that her attempt to teach Yorke to be a new man has failed. As Masteller puts it, "it is here that Phelps hesitates" (144), implying that the author simply cannot see a way to overcome the prevailing imbalance of power between genders: at the last minute, Masteller suggests, Phelps admits defeat, and hints that Dr. Zay's fears will be realized.

By contrast, I prefer to read the novel's conclusion more optimistically. The ending to the novel definitely suggests uncertainty and doubt about the ability of the medical woman to "have it all"—but the fact that perfect happiness is not guaranteed is only a realistic assessment, not necessarily an admission of defeat. As I argued earlier, while the novel has the power to make everything work out perfectly for the professional woman, no-one of the day knew for sure what that happy ending would look like (nor do many know today). Dr. Zay is not Atalanta—despite her misgivings about the possibility of happiness for a new woman such as herself, she does not want to run forever, and preserve her maiden purity like her idealized namesake. As a "real" woman, she must deal with the necessary facts: there can be no peace, no happy endings, for professional men and women unless both are willing to make *the attempt*, and unless both are willing to compromise, and relinquish power from time to time.

The discussion of intentionality is notoriously fraught, but I still believe it is necessary to consider what this novel—like the others in this section—meant to achieve as a work of propaganda. There are problems that may interfere with this goal upon close examination; nevertheless, what first presents itself to the reader's view is a vision of sexual relations where it is each individual's strengths, not his or her weaknesses, that bring out the manliness or womanliness in the other. Moreover, as all the romantic heroes in this category of doctress novel learn, the difference between competition and complementarity is in the eyes of the beholder. The generous, warm-hearted, but manly man can consent to learn a lesson and change his mind if that lesson comes in the form of a loving and womanly woman. The essential femininity of the woman doctor brings out the innate nobility of the true gentleman. In spite of himself, he appreciates her claims for justice and fair-play, the values that he himself holds most dear as an upstanding Englishman or American; and like a genuine sportsman, he is willing to look for the bright side of defeat—the resulting good will between the sexes turns what had begun as competition into a shared celebration of victory: "I don't care who has the reins," [Yorke] cried, with a boyish laugh, "as long as I have the driver!" (257).

Real women doctors in the late nineteenth century, like their fictional counterparts, also had to choose between the general options represented by these three narrative patterns. It could not have been easy to choose a path so defiant of conventional expectations, and many medical women continued to hold the conventional belief that the choice was either/or, that a woman could love either her work or her family, but not both. As a result, for those women who married, many did choose to give up their medical careers, suggesting that for them, there was indeed no competing with the demands of essential female nature. Other women who chose a medical career did so only after acknowledging that it might mean sacrificing the traditional rewards of womanhood—marriage and motherhood—in exchange for professional, but celibate, success. But according to studies done by medical women themselves, many women professionals did find it possible to combine career and home life. However, the stereotype of the medical woman as prudish spinster persisted, both in life, and, as the example of the doctress novels demonstrates, in fiction as well. Moreover, as Jurecic points out, writers like Elizabeth Stuart Phelps may attempt to portray the personal and professional lives of their women doctors optimistically, but ultimately they usually leave "the possibility of a balanced marriage of equals untested because [they] leave the marriage . . . unnarrated" (145). It is difficult to determine precisely which of the three narrative patterns employed by the authors of the doctress novels was most popular with readers; both *Mona Maclean, Medical Student* for example, and *Dr. Breen's Practice* made it to multiple editions, published in both Britain and the US—so that, for every fictional representation of the woman doctor who finds happiness in both personal and professional relationships, there was another which warned that such happiness was an elusive goal.

Despite the inevitable misgivings, however, the experiences of both fictional and real medical women proved that even when the choice between home and work seemed inevitably to favour the former, at least now there was *choice*, to an extent previously unknown by many nineteenth- century women. Women's education and professionalization brought both internal and external conflicts, and introduced the challenge of competition *with* men, rather than simply *for* them; but education for professional women also inevitably brought education to other women, and to men, and introduced, at the very least, new possibilities for relationships—economic, romantic, and some new combination of both.

Chapter Three:
Daughters of Aesculapius, Mothers to All:
Medical Women, Moral Therapy, and the Future of a Movement

Between 1870 and 1900, the doctress novels increasingly tend to portray medical women as capable of successfully managing the conflicting demands made upon them by class, gender, and profession. The majority of the doctress novels are performing deliberate work to link the fictional to the historical, using the entertainment value of the literary text to attract readers to their propagandistic content. The example of the fictional woman doctor is made to teach others—men, in particular, in the text; readers in general outside of it—that change does not equal chaos and insecurity, but that it can, in fact, be safely accommodated within the comforting boundaries of existing social arrangements. The novels use the fictional woman doctor to exemplify the late nineteenth-century feminist ideal of the educated, female professional who no longer threatens Womanhood, but is instead its best embodiment; the medical woman represents a kind of rational yet essential femininity that gently but irresistibly enlightens all who come in its path. By the end of the nineteenth century, the doctress novels have ensured that the medical woman is no longer the enemy of social stability, but its guarantor—and even, as we will see in this chapter, its enforcer. The goal of the novels in this regard is to persuade readers to modify their perceptions about professional woman in fiction, and to apply this modified understanding to "real" experience. The lesson, these novels urge, is that the perfection of womanly and maternal wisdom, and the capacity to manage and monitor, makes the woman doctor the agent of middle-class interests, maintaining social barriers even as she reforms and tidies them.

When the promotion of the medical woman was successful within popular perception, it came about both despite and because of her multiple allegiances to various social class fractions. On the one hand, as white, middle-class, lady-professionals, women doctors played a complex social role, and their loyalties fluctuated between the influences of race, class, gender, and profession to the extent that individual choices were neither unified nor predictable. On the other hand, the only way medical women could survive as a group, as a movement, in the late nineteenth century is for the group to find one common strategy for negotiating its place in society. And as we have seen in the previous chapters, this is precisely what ends up happening; whether purposely or otherwise, real and fictional women doctors proved themselves by adapting essentialist notions of gender to the goals of the medical profession and the middle class. Medical women may have owed allegiance to a variety of competing social groups—but one thing all of those groups might have taught the woman doctor is the importance of stable social boundaries. Thus, when women doctors acted together as a group, individual differences and controversial positions found one common mode of expression in the desire to endow the medical woman with the role of non-controversial agent of social improvement.

Over the course of the late-century medical women's movement, the idea of the woman doctor as an embodiment and teacher of what was called "scientific motherhood" (Morantz-Sanchez, 56) came increasingly to influence the practice of both real and fictional doctors. Scientific motherhood was a product of what Morantz-Sanchez calls "optimistic eugenic reasoning": "if mental as well as physical characteristics were inherited, the race would steadily improve, but only if women could uplift themselves" as caregivers—as doctors, social workers, or mothers—through a combination of moral and scientific education and practice (56). Other loyalties persisted among women doctors, which explains why the expression of medical maternalism took many different forms, and why medical women often disagreed with other feminists, other doctors, and each other on a variety of medico-moral issues. Nevertheless, the ideal of scientific motherhood is one concept that everyone could agree on, and so came to dominate. As a result, while early medical women claimed simply to want to feminize the growing trend towards the medicalization of society, for the protection of women and children, later women doctors ended up medicalizing feminism—using scientific principles to justify moral leadership, or control, over patients of both genders exhibiting a variety of physical and social ailments.

The doctress novels reflect this trend, and exaggerate it, by oversimplifying and minimizing complex social issues to better fit the novels' political and narrative goals. The motif of scientific motherhood in fiction was meant as both an interpretation of, and an influence on, the perceptions of at least some late-nineteenth century onlookers. The exaggerated and enthusiastic quality of this representation highlighted all that a female professional could be; at the same time, however, the conflation of medical woman with scientific mother also raised potentially limiting implications about what the female professional ought to be. As I move towards the conclusion of this project, I will explain that, while this strategy worked very well from the standpoint of the *medical* woman, it had unintended and less desirable consequences for the medical *woman*, both in and out of fiction.

I. Commonality and Contention Among Women Doctors

For the first generations of women doctors, the pursuit of a medical career was an expensive process: for all its rewards, it exacted high costs in terms of financial expense, and personal and professional conflicts with the unsympathetic. It is not surprising, therefore, that early medical women in Britain and the US exhibited intense commitment to a variety of social and moral projects: their belief in the furtherance of a larger, just cause enabled them to persevere in their unconventional careers when smaller, small-minded detractors threatened to bar their way. So that even though the very act of making one's own living was a form of social activism for all woman doctors, many women also chose medical careers as a way to bring reform to as many other members of society as possible. However, the role that many women doctors played in social change has often been overlooked or downplayed. On the one hand, the male-dominated medical profession of the late nineteenth century may not have valued women doctors' work among lower-status patients; and on the other, scholars of the twentieth century tend either to accept the medical profession's historical representation of itself without deeper investigation, or find the women's participation troublesome because it often served interests which are now considered antithetical to our ideals of social progress.

Moreover, nineteenth-century medical women do not appear as a conveniently unified group. Historically, and in fictional accounts, the image of the woman doctor as a social reformer or crusader is a contradictory one, because she represents a variety of social, political, and scientific attitudes prevalent in the day, some very much ahead of their time, and just as many others that are firmly rooted in more conservative principles. All medical women—including the fictional ones—seem to be united in their dedication to the advancement of Woman. However, their varying approaches to achieving this goal resulted in an uneven outcome, their apparent inability to see past contradictory, but essentialized, ideas of femininity imposing limitations on what could be accomplished.

Although early women doctors were definitely pursuing a highly unconventional course by going into medicine, and as a result were often seen to be revolutionary, insurrectionary, and beyond the pale, few saw themselves as being truly radical. They were far from being "New" in the ways that notable—or notorious—New Women like Sarah Grand or Olive Schreiner were, with their socialist sympathies and experiments with free love or agnosticism. On the contrary, a very large number of medical women came from middle-class families, with tolerant, but devout, dissenting religious upbringings. As a result, their feminism and interests in reform were tempered by a respect for morality and social order that made many wary of some of the more radical views espoused by less pious activists. Their involvement in controversy was not motivated by a desire to shock and appall, but was rather an unintended by-product of a dedication to a greater good:

> For many women [the combination of social, religious and professional commitment], in which they viewed themselves as responding to the call of a higher moral power, helped to legitimate their deviance from prescribed female roles and strengthen their efforts to widen the paths of women's

> work despite familial disapproval and social opposition. (Morantz-Sanchez, 104)

At the same time, their unprecedented role as female professionals endowed them with an influence, and a sense of responsibility, that many other reformers did not share. Consequently, when it came to the matter of combining personal and professional values, there were never any simple or obvious choices for the medical woman. The extent to which women doctors chose to integrate social and political activism with their medical practice depended on an interaction of four general influences in their lives: medical training, religion, class, and their own views on the subject of gender roles.

As I have mentioned previously, it is important to remember that "science" in the nineteenth century was very much an evolving paradigm. Even within mainstream science, there were often wildly divergent and haphazard attitudes towards the so-called "facts" of life. Each competing school of thought attracted earnest and intelligent followers; up until the advent of germ theory it seemed to many that "irregular" medicine was just as reliable as the regular, conventional variety. And despite the fact that germ theory and increasing advances in scientific knowledge and technology eventually did make "regular" medicine a more rigorous and accurate mode of practice, many doctors still preferred to pursue alternative therapies that seemed to be more holistic, emphasizing the health of the patient's soul and mind, as well as of his or her body.

The conflicting attitudes dividing women practitioners such as Elizabeth Blackwell and Mary Putnam Jacobi are a case in point. As historian Regina Markell Morantz describes, Elizabeth Blackwell regarded the germ theory with suspicion (as did Florence Nightingale), partly because she had received her medical training before the 1870s and'80s when the theory became accepted practice, and partly because medicine was, for her, not an end in itself, but only one means among many for answering a more profound moral and spiritual vocation. She was remembered by some as a "Swedenborgian-theosophical-theological-Christian-metaphysician, instead of just an unadulterated scientist"

(Morantz, 460); the result was a "sentimental" approach to medicine which emphasized holism over somaticism (the treatment of the body) alone.

According to Morantz, to doctors like Blackwell, scientific belief in bacteriology or vaccination was a dangerous diversion from what had to be the real subjects of a doctor's attention: the social and moral environment of the patient. Blackwell rejected a view of medicine that treated disease with a series of shots and tests, but ignored the underlying causes—such as poverty, ignorance, and what she saw as immoral, or irreligious living:

> The first radical error of the modern bacteriologist is, to regard [the] germ as the cause, instead of the result of disease,—an error directly resulting from disbelief in creative beneficence, and from the wrong doing of deliberately producing disease in the lower animals . . . We do not yet know in what way special combinations of insanitary conditions, i.e., violations of Divine Law, will originate small-pox, erysipelas, phthisis, etc. ("Christianity in Medicine," 13)

Mary Putnam Jacobi, by contrast, was a pure scientist through and through, with little sentiment about her in the professional domain. Jacobi was committed to a variety of measures for social reform, but these interests were completely separate from her approach to disease. Physical ailments needed to be treated with physical solutions; and therapeutics and research methods that to Blackwell may have seemed invasive, or even brutal—like vaccination, or vivisection—were to Jacobi valuable, necessary, and completely ethical, since rational science had no place for the kind of irrational cruelty Blackwell was concerned about.

But while many medical women shared Jacobi's faith in science, they did not find it to be as straight-forward a matter to separate it from their spiritual faith. Many late nineteenth-century doctors—especially women—came from strongly religious backgrounds. Despite the relative absence of formal religious sisterhoods in predominantly protestant countries like the US and Britain, many women were still raised to believe that a life of service to others was the most appropriate and rewarding way for them to express their faith. And yet, as many women had observed, even without the rules of the convent, their ability to act on their faith was often limited by the conventions of their religions. Consequently, the combination of religious and professional vocation often rose up either in reaction against conventional teachings, or it flourished within unconventional, dissenting denominations. For example, Florence Nightingale was only one among many who made the connection between physical and spiritual healing as a natural calling for women; her nursing sisterhood was a modernized version of traditional religious sisterhoods, integrated into the secular and public domain. Many women doctors—as well as ministers and political activists—were Quakers, thanks to that denomination's acceptance of women's spiritual and pragmatic abilities; Sophia Jex-Blake contemplated becoming a minister before she found her vocation in medicine; and Elizabeth Blackwell spoke and wrote as much about faith as about science.

Hence, because of the strong role played by religion in the lives of many women doctors, their scientific knowledge was no doubt influenced by earlier moral training which viewed personal moral accountability as a key factor in a long and spiritually fulfilling life. And as the comparison of Blackwell's and Jacobi's positions make clear, some doctors more than others, of either gender, believed that moral, ethical and spiritual concerns were separate from, and superior to, the concerns of science:

> The Art of Healing is the noblest of all human arts, when moulded by religious truth; for the attainment of a sound body as the organ of a sound mind, by obedience to God's law for the body, is the foundation for all other arts, the guardian and guide of our distinctive earthly life. Irreligion in medicine, would render it the most dangerous of all arts, and the surest agent in the destruction of the race. The rejection, therefore, of religious principles as the guide in medicine, or any refusal to apply to the practice of medicine and to the methods of advancing medical knowledge, the

> everlasting principles of justice, mercy, and hope, embodied in christianity, opens the door to dangerous and degrading error in medicine. (Blackwell, "Christianity in Medicine," 9-10)

Such practitioners believed that, in fact, science was not inherently moral because inherently pure, disinterested or rational. Rather, they felt that because science was practised by erring humans with human flaws such as selfishness and even sadism, it was vital for the ethical, reform-minded doctor to practise moral leadership among both patients and colleagues for the good of all:

> What has the physician to do with the great social questions? I answer, His relations to such questions place him on a footing equal to, if not above, that of the spiritual advisor. No-one comes in daily contact oftener with his fellow-men than he. He is their firm friend and recognized superior in matters pertaining to a knowledge of nature and her laws, which he is in duty bound to promulgate every day. (Kohl, 968)

For women doctors in particular, this belief in the moral dimension as a component of preventative health care was further channelled through certain attitudes born of one feature shared by almost all early women doctors. Because of the expense of preparing for and pursuing a medical education, almost all women medical pioneers tended to come from the more comfortable middle classes, and as a result, identified themselves—and were identified by others—as ladies. As such, as lady-doctors, their knowledge gave them the power to treat disease; their social status—as guardians of the highest civilizing virtues and Christian morals—gave them the power to treat *vice*.

However, although women doctors may have all been authorized by their social status to implement moral therapy in their medical practices, it seems that often the deciding factor in the degree to which they actually did so depended very much on each woman's own sense of herself as both doctor, and lady—and not all women shared the same ideas about the nature of "woman's mission, " or how best to accomplish it. For example, women like Mary Putnam Jacobi or Elizabeth Garrett Anderson may both have seen the need to act and appear ladylike and suitably feminine. At the same time however, they also believed that it was necessary for them to practise medical science seriously—as determined by the medical mainstream—if they wished to be taken seriously themselves: "Women felt they had to adopt the male values that judged femininity a distraction to professional work" (Glazer and Slater, 87). Their goal, as medical women, was to prove themselves equal to their male colleagues, in those fields of medicine deemed to be the most masculine—namely research and surgery. It was not their business necessarily to feminize medicine—if moral therapy, for example, was seen to be a more feminine concern—but rather to adopt the habitus of the mainstream medical man, stereotypically characterized by a belief in rationalist, somaticist, allopathic practice.

For women who chose this path, it often happened that they identified themselves as doctors first, women second—since, in this view of feminism, sex should not be the primary point of division. It was not that they abandoned their femininity, or their commitment to women's advancement; but rather, when it came to questions of science, women like Jacobi and Anderson often dismayed their feminist colleagues by espousing beliefs regarded to be particularly masculine—and sexist. In turn, these medical women were often frustrated by their sisters' inability, and refusal, to accept reason and science as guiding principles. Jacobi, for example, wrote frequently of the impatience she felt towards her one-time teacher, Blackwell, who, like many other medical women, most pointedly did not put science ahead of what she saw as women's central concerns: "You have always disliked, ignored and neglected medicine!" Jacobi accused her (qtd. in Morantz 460-61).

But Blackwell, like other women doctors, including Mary Scharlieb and Arabella Kenealy, belonged to a very different school of thought when it came to defining the proper obligations and role of the medical woman in society. As we have seen, women like Blackwell put moral concerns ahead of science—and unlike their more resolutely rational women colleagues, they did so because they put their status as women ahead of their status as doctors. For them, the goal was not to erase sexual difference as a factor in medicine, but to accentuate it. Adopting what was seen as the masculine point of view towards medicine would not only be bad for feminism, it would also be bad for the practice of medicine in general. Sophia Jex-Blake and others had argued for the inclusion of women in medicine on essentialist grounds—that medical practice was a logical extension of woman's natural maternal impulses, and her natural role as guardian of both physical and moral health in society. Medical women like Blackwell, Scharlieb, and Kenealy elevated this essentialism into what Morantz calls "female chauvinism." To them, the advancement of women's interests in society meant protecting them from male immorality in general, and male scientific amorality in particular, while at the same time reinforcing the idea of Woman so popular among so many men and women of the day, as being most fulfilled in social and biological maternity.

As Morantz-Sanchez, Glazer and Slater, and Ehrenreich and English confirm, it was this latter view that tended to predominate among medical women of the late nineteenth and early twentieth centuries, probably because the gender essentialism at its core made it more easily integrated into both feminist and conservative ideology. The medical woman as surrogate, scientific mother to the nation allowed for women to pursue an unconventional career, thus contributing to women's educational and professional development generally, while at the same time tending to reinforce more middle-class interests and values than she threatened to overturn.

Nevertheless, despite this general agreement on the importance of scientific motherhood, there was no simple compromise or agreement among either feminists or their opponents on the correct position that medical women were to take on particular medico-moral issues of the day, such as vivisection, the Contagious Diseases Acts, purity campaigns, public health, or politics—with the result, once again, that an on-going discussion took place in the popular press on all subjects. And largely due to the efforts of feminist reformers like Josephine Butler or Francis Power Cobbe, frank discussion of the facts came to be considered the healthy norm, as opposed to polite silence or euphemism. Thus, when women doctors took stands on issues, whether for conservative or radical ends, they had to be willing to be similarly blunt and unmistakably to the point.

Such was not usually the case for fictional women doctors. While many of the doctress novels do touch on some medico-moral and political controversies, it is generally the woman doctor who is the unconventional element in the novel, rather than her political attitudes. Especially in the case of those novels that are in favour of women doctors, the authors seem to be more concerned with integrating the doctress into the status quo—promoting medical women as competent professionals who have the right to their place within the increasingly prestigious field—than they are with overturning the status quo altogether. As a result, many of the novels simply do not touch the more shocking contemporary controversies—such as vivisection or the CD Acts—or touch upon them only extremely lightly. And as the examples which follow demonstrate, if the woman doctor does become involved in a delicate political case, her own position often turns out to be properly conventional—with only a few notable exceptions.

II. Women Doctors as Medical and Moral Missionaries

One field of medicine most often chosen by late nineteenth-century women doctors was that of medical missionary work: once women gained access to medical educations in Britain and the US, large numbers of them decided to set up practice among the colonial outposts of the Western empires, especially in India and Asia. While most "medical missionaries" were motivated by evangelistic ideals, not all believed in the dual purpose "not merely of curing, but of christianizing [their] patients" (Elmslie, 191). Moreover, while the missionary societies stressed the importance of using every opportunity to incorporate Christianity into medical practice, the local people in the colonies often only wanted the latter, without the former. Leading medical women like Sophia Jex-Blake were concerned that the great need for medical missionaries abroad was leading many missionary societies to put a higher premium on religious zeal than they did on scientific training: "An obvious and easy remedy unfortunately presents itself only too temptingly in the employment of women very imperfectly qualified for their work by an incomplete and insufficient education" ("Medical Women," 703). Consequently, many of the local men who funded the women doctors in the colonies made it a condition that they not attempt any specifically religious or political proselytizing (Jex-Blake, "Medical Women," 702). The women doctors brought out by the medical-missionary organizations accepted the condition gracefully for the most part, believing that it would be one more instance of the superiority of the doctor-as-lady, to be able to lead her colonial subjects simply by her own good example: "Apart from any words that may be spoken there is always the opportunity in medical work to preach the gospel of love in the concrete terms of friendly service" (Lambuth, 148).

In areas like India or the middle-east, the problem that the women doctors were specifically needed to address was the harem or zenana—among a large proportion of Indian society, for example, many women lived in purdah, untouchable to any man outside of their family, including male doctors. While the male medical profession in Britain and America was contemptuous of the idea that western women, raised in their own separate sphere, would be more comfortable with doctors of their own sex, male doctors abroad immediately recognized the disastrous consequences of enforced female modesty, where untold numbers of women suffered and died because they could not have access to trained medical care.[1] For this reason, the British surgeon, Dr. Corbyn, began a medical school for local women in 1867 at Bareilly; the American doctor Clara Swaine "enjoy[ed] the distinction of being the pioneer of women's medical missionary work in India" (Lambuth, 136) by taking up a post at the school. The medical school graduated its first Indian nurses in 1873, and expanded into a teaching hospital, the Madras Medical College, in 1875. But while India was slowly building its own corps of women doctors, Indian women were still suffering. It was estimated that at least 1025 women doctors were needed in India in 1880, when, in 1887, "there [were] but fifty-four women, all told, on the British Register!" (Jex-Blake, "Medical Women," 701).

In 1883, a committee of "native gentlemen" led by Jamsetjee Jejeebhoy established the Bombay Medical College, under the medical direction of Edith Pechey—a veteran of the Edinburgh struggle. Other colleges and hospitals followed, including an expansion of the Madras facility under the direction of Mary Scharlieb. But with all the resources ready and waiting in India, there was still a great need for women doctors to fill the vacancies. Promoted and funded by the Countess of Dufferin's National Association for Supplying Female Medical Aid to the Women of India, and endorsed by Queen Victoria herself,[2] the movement for women medical missionaries played a vital role in legitimizing the cause of women's medical education in the UK, and, following closely behind, the US.

Even to those American and British commentators antagonistic towards women doctors—male doctors jealous of their professional privileges and status, conservative critics fretting about the future of the nation and race—it was apparently possible to isolate the woman medical missionary as a separate, acceptable phenomenon. At home, the woman doctor threatened to completely destabilize western middle-class society; but abroad, she was the perfect representative of that same society's imperial project. Colonial subjects may have had mixed feelings about female medical missionaries, as they may have had in regards to most colonial undertakings; nevertheless, to western observers, women's involvement in colonialism was seen as a natural, maternal, but safe, outlet, for their nationalist and philanthropic urges:

> . . . in the days when women did not vote . . . [their] only avenue for patriotic contributions to the well-being of the nation and empire was via motherhood. The quality of motherhood was seen as directly affecting the quality of the "future citizens" (read "male children")—which in turn determined the vigor of the imperial race. The establishment of English homes in the colonies increased the avenues through which Englishwomen

> could directly contribute to the national enterprise of imperialism as well as earn recognition for their labor. And such contributions were rarely in the conventional category of "motherhood." (George, 98)

In India, for example, the medical woman would not be competing with middle-class men for status and money, nor would she be challenging their masculinity. Instead, she would be disregarding colonial masculinity by stepping in to take on the role of imperial mother to the childlike, primitive natives; her benevolence, nobility and maternal, healing powers would make an excellent complement to the rule of the paternalistic male colonial governor.

And yet, many women seemed to have come away from their experiences in the East with a heightened respect for their foreign "sisters"; Lady Dufferin, for example, found that the women of India led lives that were, to her British sensibilities, perfectly respectable and even moral, under what she saw as heathen circumstances. As a result, it was Lady Dufferin's aim, in promoting the work of medical women in India, to help the capable women there to help themselves, rather than to blatantly enforce unwanted British "help" where it was not wanted:

> . . . the very best way in which we can help our Indian sisters is by supplying them with medical relief. I must confess that I think it is; because it aims at diminishing suffering and at saving life; because education and general enlightenment must follow in its train; because it encourages and inculcates respect and consideration for women; because it brings cultivation and learning in contact with the *zenana*; and because in medicine and nursing Indian women will find professions open to them which they can take up with profit to themselves and advantage to their fellow creatures—professions in the exercise of which widows, deprived as they are of home and family ties, may fill their lives with all the interest, occupation, and honour, so sadly wanting in their present state. ("The Women of India," 365)

In 1899, missionary J. Rutter Williamson reported that

> the total of medical missionaries at present is 680; of this number 470 are men and 210 women. There are 45 medical schools and classes [in the colonies], with 382 male and 79 female students . . . [There are also] 240 female medical students now in training as physicians, nurses and hospital assistants, under the care of the Lady Dufferin Association in India. There are 348 hospitals and 774 dispensaries. (93n)

Williamson estimates that these collected medical missionaries had treated 2.5 million patients annually. However, despite the growing numbers of opportunities for the imperially-minded woman doctor in real life, colonial adventures account for a puzzlingly small percentage of the doctress novels I have come across. In fact, Hilda Gregg's *Peace with Honour* (1897) is the only full-length example I have found so far. Hilda Gregg herself, in a review of doctress novels, speculates that perhaps the colonial backdrop was "ground already occupied" ("The Medical Woman in Fiction," 106) by none other than Rudyard Kipling, who had featured a nurse as a beleaguered medical officer in *The Naulahka*. However, Kipling's Nurse Kate hardly cornered the market on women's medical adventures in the "East." One reason for the under-representation of the woman medical missionary in fiction is that she may have been a victim of publishing dictates. As Daly's study of what he terms the "imperial romance" suggests, strong female protagonists and colonial settings just did not go together. The generic conventions of the imperial romance calls for the construction of "an all-male 'family' or team, and replaces the heterosexual romance with strong affective . . . ties between men" (Daly, 62). Imperial romance writers like Kipling or Haggard might create forceful female characters, but in so doing they would also "assimilate many of the 'strong' qualities of the New Woman, only to put these qualities in the service of the texts' men" (Daly, 65). Thus, the colonial setting may have been made to be no place for a woman, by men writing with a male audience in mind.

Moreover, although late-century girls were reportedly fond of books meant for boys, including action-adventure stories, what reviewers and parents selected for young women readers was another matter (Rose, 201). As Tuchman further observes, publishers' readers often acted as critics and arbiters of taste; they were given the authority to select not only what would sell, but what they deemed was worth selling—which often meant works which would be favoured by a mainstream and conservative audience (67-68). Thus, while colonial adventures were great fun for boys and men to read, such exploits—with the woman doctor thrown into the mix—might have been considered either too strong, or too dull, and so too unprofitable, for young women readers, whose own preferences were not consulted.

At any rate, Gregg's fictional Dr. Georgia Keeling performs admirably in bringing healthy British customs, including romance, to the East, in this case a remote border kingdom in Ethiopia. Georgia's father was General George Keeling, who had first established British law and order on the Khemistan frontier; Georgia is a proud Englishwoman and imperialist who sees herself as continuing the assimilationist effort her father sponsored in order to civilize the region: "It was my father's country, and it is mine" (29). She has joined the trade mission as a way of gathering information about where she could most usefully begin her career as a medical missionary.

Like her companions on the trip, Georgia regards the local culture with condescending amusement, or contempt, as she feels the situation warrants, and only conforms reluctantly to certain customs—like wearing a veil—out of respect for the trade mission, rather than for the Khemistanis. Georgia, like Lady Haigh, wife to the mission's leader, is unmoved by custom or religious sentiments; as Lady Haigh puts it, "people must learn not to let their feelings be hurt so easily" and the people "ought to accustom themselves to seeing new things" (66). In the belief that the only good way is the British way, the British contingent is not interested in understanding the local customs; Lady Haigh, like all of her travelling companions, seems not to feel any sense of hypocrisy when *her*feelings are hurt, or her sensibilities offended, by "seeing new things." Georgia is only persuaded to wear a burka by Lady Haigh's sincere invocation of stereotypes. Georgia must hide her irresistible, white, attractions to avoid risking her safety, and that of the mission, by provoking a diplomatic incident should the local ruler notice her, become overwhelmed by savage desires, and insist on having her as an addition to his harem.

But while Georgia consents to veil herself when in the company of local men, she makes no further concessions to Khemistani—or British—ideals of female modesty or fragility. In the doctress novel of the wild East, the British romance heroine is also the representative of her nation, and as such is expected to endure scenes of—what is to her—native barbarism with patrician sangfroid. For example, when the mission is attacked by a local mob, the men deal with this "violation of courtesy and propriety in the attack made on the flag" (127) by giving their disorganized and weak foes a good sound public school thrashing with sticks. The ladies observe from a balcony, only interfering to request that "the people not . . . move quite so much, because [they] wanted to sketch them" (128). The local king's Vizier, hoping the attack would drive the English party out, is dismayed that even the ladies are unfazed, and is far from being as impressed with their stiff upper lips as the English officers are:

> "[B]y the head of our lord the King," burst out Fath-ud-Din, . . . "these are no women, but fighting men!"
>
> "Isn't it worth your while, then, to strain a point in order to gain an alliance with a nation that has such women?" asked Sir Dougal.
>
> "Nay, rather . . . what are we doing to admit within our borders a nation whose very women are of such a temper as this?" (130)

The members of the trade mission make sure that Fath-ud-Din meets the ladies for himself, and sees their utter lack of concern. Perhaps in a confrontation with other white men, the Englishwomen would be expected to cower meekly behind the protective shoulders of their escorts. On the frontier, however, the need to create a unified impression of British mastery overrules customary gender conventions, and demands that the women display as much courage as the men. The women's fearlessness shows their confidence in the superiority of their party's military and moral strength, and their contempt for the underhanded and ineffectual tricks of the inferior Khemistanis. The Khemistanis and the Englishmen share patriarchal and sexist assumptions about the inherent frailty of "their" women; so by showing their enemies how unmoved even the delicate women are by the display of aggression, the British envoys are deliberately deriding the Khemistani claims to masculinity and power.

Georgia is eventually called in to tend to the King's first wife and daughter-in-law; and because of her intimate access to the harem of the local ruler, Georgia becomes the most familiar of the whole group with the "native" way of life. However, this does not do anything to increase her respect for it. Like the officers and diplomats with whom she is travelling, she sees the Khemistanis as childish, corrupt, superstitious, and disorderly—all qualities which the trade mission can exploit for its own defensive, and offensive, purposes, but which must ultimately be trained out of the people if they are to make good colonial subjects.

For the time being, however, while Georgia is able to enter the harem by express invitation, she is also ordered not to make any attempts at converting her female patients to Christianity and other English beliefs: "You need not describe to her English life and the Christian position of women, and all those other luxuries of civilisation of which you are the culminating product, need you? It could do no possible good, and it certainly would do a great deal of harm, for things of that kind are absolutely unattainable here" (96). This warning comes from Jahan Beg—or John Bigg, an Englishman who has been living as a Khemistani for the last several decades. Although he feels tied to his adopted country, he still retains an English contempt for it, and an assumption of its inferiority. Despite having assimilated into Khemistani society to the extent of becoming a high-ranking member of the king's court, he has remained immune to any suggestion that the Khemistani culture has merits of its own, and is convinced that the slightest hints of English life will prove devastating temptations to his locally-born daughter.

Georgia feels that to promise to hide her culture's light under a bushel is somehow dishonest, and immoral, in that it may give the "natives" the idea that local, Islamic customs are actually tolerable to the British. But she is forced to accept that integrity and duty to one's nation sometimes supersedes the dictates of individual conscience, and so limits her efforts among the harem women to impressing and intriguing them with her actions, rather than her words. As Dick North points out in a moment of clarity, "At any rate, you will make friends with the ladies, and perhaps the memory of your visit may prepare the way for a regular missionary when the country is opened up later on" (99).

When Georgia is called in to treat the women of the royal zenana, she refuses to indulge in the harem's political conflicts, instead asserting herself as an irresistible force of Western cleanliness, science, and morality, not necessarily in that order. This blend of maternal care and powerful scientific medicine that characterizes Georgia the lady-doctor is sharply contrasted with what Georgia sees as the corrupt, ignorant, and dangerous folk-medicine of her rival, Khadija, the "witch." Khadija is shown to be a conniving poisoner, more than a healer—but even the much-feared witch is forced to give way to Georgia's superior medical and moral skills.

Georgia's approach of guileless temptation through superior example is meant to prove more subversive of local culture than coercion through violence, or the overt teaching of Christian humility. The novel shows a complete lack of awareness of how a society such as that of Khemistan (itself a fictional amalgam of colonial stereotypes) might perceive the British, and blithely assumes that any "savage" society must be favourably impressed by the mere glimpse of British culture embodied by missionaries like Georgia. Georgia leaves behind her women who are awe-struck by her knowledge, her independence, and the respect she is able to command among men, setting an admirable example in fiction for real-life women, both Eastern and Western, to follow in her footsteps as a medical missionary, as so many in fact did.

I would argue, then, that the novel is not so particularly concerned with the attitudes of the colonized people, as it is with the behaviour of the colonizers. Georgia's ability to hold her own under duress refutes "Kipling's and other writer's renditions of [Englishwomen abroad] as 'idle, frivolous and luxury-loving'" (George, 111-12). Despite the magnitude of the struggle for respect and recognition for medical women at home, Georgia demonstrates that the "strong-minded" and highly trained colonial woman can more than equal her male medical counterparts. Through a combination of professional training, womanly sympathy, and maternal leadership, the medical woman abroad has the power not just to cure, but also to convert untold numbers to British spiritual and cultural dominion. This demonstration of Georgia's ability and competence overshadows the novel's treatment of the unfortunate and benighted colonized women, while at the same time providing a justification for the professional woman's claims for equality and authority.

Such an approach, I would suggest, is in keeping with observations made by both Burton and George, respectively. In fictional and non-fictional narratives of colonial life, they argue, reform-minded women often cited the suffering of native women as their primary interest, but then used the resulting scenes of benevolence and moral leadership on their parts as a means of promoting the rights of white women to involvement in imperial government both abroad, and more importantly at home. Burton, in particular, emphasizes that feminists exploited the misfortunes of the needy in both the east and the west, ostensibly out of nationalistic concerns, but also as a way of producing clear evidence of white women's claims to greater power:

> Middle-class women's moral authority, much like imperial authority, relied on the existence of a dependent class whose moral redemption was as important as their material needs. Feminists interpreted protection as moral

> authority over Britain's dispossessed, thus transforming the human capital of the poor into the symbolic nation that British women were responsible for saving. (45)

Medical women were uniquely situated to exploit the public relations potential offered by the poor, the ill, or the misguided. From the standpoint of public health, moral hygiene, and racial fitness, there was a genuine need for organized, decisive action to bring a "civilizing" influence to both colonial and domestic subjects. With their claim to a kind of professionalized womanliness and maternal authority, women doctors seemed eminently well-suited to meet this need. And by doing good for others through her proselytizing about moral and physical hygiene, the medical woman also did good for herself and her cause. Of course, self-promotion was not a stated goal, for medical women or feminists generally—but the sincere selflessness which did seem to motivate these women only served to reinforce their claims to a participatory role in the public life of the nation.

Medical women, like many feminist reformers, seemed whole-heartedly to believe in their own propaganda: they felt themselves obligated, but also specially qualified, to foster civilization and the improvement of the race as well as simple good health, not simply abroad, but at home as well. The impetus to colonize—to make over the other in the western, middle-class image—was both the motive and the justification for many feminist reformers, who believed that their maternal authority could usefully extend beyond the confines of the home:

> Under feminist auspices, women's guardianship of the race was not a separate or private function, in the sense that it was not limited to the domestic sphere of child-rearing. As with femaleness, the moral responsibilities inherent in motherhood legitimized, if not required, women's participation in national political affairs. Responsibility, in other words, had its privileges, and feminists argued that the racial

> responsibilities incumbent upon women authorized full equality in the public sphere—whether it be municipal or parliamentary politics . . . (Burton, 51)

. . . or, I would add, the professions. The responsibilities and privileges of maternal womanliness, so central to real women's claims for equality and influence, were a similarly essential part of the doctress novels' strategy to portray the doctress as a positive role model and arbiter of social change in fiction. Thus, in addition to the fictional doctress' role of re-vamping the romance heroine to accommodate broader female ambitions within the bounds of femininity, she was also often portrayed as taking the most highly idealized skills and qualities of domestic, maternal, womanhood out of the middle-class home, into the lives of the lower classes, for their own good and whether they liked it or not.

Charles Reade, for example, in *A Woman Hater* (1877), seems to have wanted to make a point of showing the medical woman as combining the best qualities of the ideal Woman and the ideal doctor. Rhoda Gale exhibits feminine compassion, curiosity, a housewifely love of managing, a charming penchant for girlish tyranny—and a maternalistic urge to both protect and direct. At the same time, Reade shows her as being the product of rigorous intellectual training and worldly experience more stereotypically associated with the medical man and, at the time, still kept largely off-limits for young ladies like Zoë and Fanny, the novel's conventional romance heroines. As a result, Rhoda is completely immune to the charms of the picturesque and adorable: where Zoë sees pretty flowers, Rhoda sees deadly poison—which, in her trained hands can be used responsibly for powerful medicines; where Zoë sees charming dilapidated cottages overgrown with roses, "the show place of the village" (335), Rhoda sees plants thriving, and the ignorant peasants declining, because both cohabit over human refuse. It becomes Rhoda's self-appointed task to protect others from themselves through a policy of parental monitoring and regulation. Rhoda thus becomes an exemplar, or caricature, of what Reade envisioned the medical woman's natural role—the public health inspector and activist—combining her inherent feminine love of physical cleanliness and moral order with a masculine insistence on unsentimental action.

Rhoda's position on public hygiene is accurate and realistic—Vizard's tenants do need fresh water and proper sanitation—and sets a positive precedent for the impressive effects a caring and competent medical professional, of either sex, could have on the lives of numbers of people. But while Rhoda is striking a blow for public hygiene and for the role of the medical woman in its promotion, she, through Reade, is also reinforcing a status quo that would deny as many social changes as it would create. If Reade occasionally wanders into the realm of caricature in his portrayal of Rhoda, that is nothing compared to his treatment of Vizard's poor tenants and those of his neighbour, Lord Uxmoor. They are shown to be ignorant, rustic, and completely impervious to education; as Uxmoor puts it, "That is the worst of it; they resist their own improvement" (334). Unlike the inhabitants of the manor, the villagers are comically oblivious to the advance of civilization that has taken place among the upper classes, exhibiting willfully irrational prejudices and an almost bestial resistance to change. "Confound the brutes!" Vizard exclaims, when Rhoda tells him that one tenant family is living crowded together in one room—a sure recipe for medical and moral illness—and using the extra living space that Vizard has built for them as a cold room for potatoes (334).

Rhoda holds Vizard and Uxmoor accountable for the poor health of their tenants, and demands that they take responsibility for improving village hygiene, thus apparently striking a blow against aristocratic indifference and undemocratic neglect of one's fellow man. But Rhoda is no crusader for class reform and equality: the village peasant making tea with the same pond water that serves as his sewer is not a "fellow man"—not equal, because barely even a "man" at all. She must cajole the local leaders into forcing their reforms on the people, since they are not capable of improving themselves, according to her standards, on their own:

> "What can I do more than I have done?" [Vizard asked].

> "Oh, it is not your fault," said the doctress, graciously; "it is theirs. Only, as you are their superiors in intelligence and power, you might do something to put down indecency, immorality, and disease." (335)

Rhoda Gale, and many fictional women doctors coming after her, exhibit a similar attitude: their pursuit of a medical career is motivated by the most noble sense of a calling, a duty to serve humanity, and improve it. And yet their apparently irreproachable good intentions are founded on a deeper assumption that "humanity" is a relative term, and that it only needs as much improvement as it does because it is being degraded from within by those members who are the most ignorant, amoral, and impervious to change: "Whether depravity had bred destitution or vice versa was the subject of considerable discussion . . . but whatever the cause, the result was a class of people as physically and morally 'other' as a separate species or race"—the lower classes (Matus, 57).

The issue of public hygiene and health education is thus not simply a matter of bringing comfort and dignity to selected groups of the deserving poor; it is not simply a matter of disinterested charity. Rather, it is very much a self-interested and urgent measure that the middle classes—through their appointed health officers—must impose on the lower classes in order to preserve not comfort, not dignity, but the very race itself. As Rhoda observes, every generation of the working class is in poorer health than the last, living a shorter life, and characterized by "half-grown, slouching men . . . hollow-eyed, narrow-chested, round-backed women" (338), and boys with "no calves to their legs . . . a sure sign of a deteriorating species" since "[t]he lower type of savage has next to no calf" (337). The unspoken fear, Rhoda implies, is that such a diseased but prolific group threatens to undermine the economy, the social order, and the superiority of the white race itself.

Both Rhoda and her fellow-practitioner, Arabella Kenealy's Dr. Janet (*Dr. Janet of Harley Street*, 1893), place the blame for this dire state on the declining classes themselves, reflecting the common belief that disease was produced as much by deliberate immorality as by pathogens—or, before the advent of germ theory, miasma. Germ theory may have eventually made it possible for medical practitioners to understand how disease and generational decline worked, but it was harder to change biased ideas about the reasoning for such phenomena. Faith in the social order and Christian morality was so strong that many nineteenth-century people, no matter how scientifically educated, had great difficulty in changing their understanding of the causal relation between poverty and disease to see, for example, that often the latter brought about the former, rather than the other way around. "Health" did not happen on the physical level alone; many shared Elizabeth Blackwell's views that health came about through a combination of physical and moral choices made by the individual. Only individuals with strong, moral wills could make the correct choices for themselves; if they proved incapable of making such choices responsibly, then others would need to do the decision-making for them.

Physicians, both male and female, stepped forward to offer themselves as the experts in this medico-moral question (Morantz-Sanchez, 291-92). At a time when religious institutions were facing their own destabilizing problems, the empirical interpretation of morality offered by the medical profession seemed reassuringly rational and attainable, as long as it was properly administered. And who better to decide on the correct dosages of this new moral therapy, than those physicians who best embodied the combination of professional science and pious, motherly, domestic virtue—women doctors?: " . . . [I]n these little domestic matters . . . women are good advisers . . . The male physician relies on drugs. Medical women are wanted to moderate that delusion; to prevent disease by domestic vigilance, and cure it by well-selected esculents and pure air" (Reade, 336). Every advance made by a woman doctor like Rhoda in the realm of physical and moral hygiene not only helped the designated patients—it also provided further justification for the medical woman's involvement in preserving the health of the nation.

Medical women did not confine themselves to doctoring lower-class morality alone. That there was even a crisis at all—a threat to racial purity and superiority—was at least partially the fault of the middle and upper classes too: the lower classes had brought themselves to their present low pass through immorality, but only because their betters had allowed their leadership to weaken. The result of progress was complacency, and arrogant disregard for the demands of one's so-called natural roles, especially in terms of gender. How could the lower classes be expected to live moral, structured lives, when the middle and upper classes were living amoral, unstructured lives, characterized by a disregard for the ordering of society according to sexual identity?

For medical practitioners like Rhoda Gale, the corrective to this situation had to start with the poor—improving their health and hygiene through the no-nonsense instruction of medical-maternal authority figures like herself. Dr. Janet would agree that the poor did indeed need guidance and control; but in frequent discussions on the issue of racial health, she works her way up the class ladder, taking her own circle to task for allowing the devolution of men and women into effeminate men, mannish women, and so-called "neuters" like herself. As Dr. Janet explains, soft living, idleness, and dissipation, have caused society to "devolute," to stagnate in its progress away from the savage, neuter state to the more elevated distinction between the sexes:

> How many women now-a-days have any of the instincts for home, and wife, and motherhood, which are the crown of their lovely sex? . . . . [The] men of today . . . are as neuter as we . . . Only a fine, natural, healthful parentage and training produce men and women; modern civilization, with its artificial modes of life and thought, causes devolution and the production of neuters. (256)

Dr. Janet, like her creator Arabella Kenealy, reflects the increasingly popular view among late-century medical practitioners, including medical women, that the future of the race could only be safe-guarded by careful selective breeding among all classes: "It was [Dr. Janet's] pet theme, and she oftentimes astonished the parents of sickly or evilly-disposed children by asking them fiercely, were they not ashamed to have brought such 'human rubbish' into existence, or so to have bred them that their health and better feelings wasted" (194). The poor could be eliminated as a class altogether if only well-educated and healthy women were allowed to reproduce, and this could be accomplished only if women, as a group transcending class lines, could be persuaded to go back to their natural roles as mothers. This did not mean abandoning the feminist goals of improved education and opportunities for women: Kenealy believed a good mother had to be intelligent, and in the event that not all women could marry and raise children under the natural protection of a husband, some educated women could certainly work as doctors, or teachers, or in other professions that would contribute to the improvement of the race. But it did mean scrupulously avoiding any masculine behaviour or appearance, or any unsuitably masculine claims for full equality, that could interfere in a woman's complete devotion to the task of reproducing healthy and worthy little bundles of racial purity:

> All that I would warn her against is the error into which she has been temporarily led, the error of supposing there is any nobler sphere than that of home, that there is any greater work than that of bearing and training fine types of humanity, seeing that this is the sole business wherewith the mightiest forces of the universe and evolution are concerned. But these things to be wholly worthy must be intelligently done. The reign of mere instinctive motherhood is waning. The era of Intelligent Motherhood approaches. And the first task of Intelligent Motherhood will be to see that none of those powers which belong to her highest development and through her to the highest development of the race shall be impoverished, debased, or misapplied. (Kenealy, "Woman as an Athlete," 645)

Kenealy, and her narrative alter-ego, Dr. Janet, are the most extreme examples of just how far the medical woman could go in her promotion of "intelligent" and scientific motherhood, for women and women doctors respectively; most of the other fictional women doctors, like their real-life counterparts, have not developed their eugenic theories to quite the degree that Dr. Janet has. Nevertheless, almost all of the doctress novels make the connection between the health of the individual and the health of the race, reflecting the concerns of increasing numbers of physicians and social reformers in the late nineteenth century. Nan Prince for example, while expressing few opinions herself, becomes, through her apprenticeship to Dr. Leslie, the vehicle for his, and the author's views on the future of the race. Like Dr. Janet, Dr. Leslie also believes that moral and physical ignorance is leading to a genetic decline. The doctor's role is almost more important than that of the minister, since spiritual improvement cannot come about until a person has received an appropriate education in the facts of health:

> It is not to keep us from death, it is no superstitious avoidance of the next life, that should call loudest for the physician's skill; but the necessity of teaching and remedying the inferior bodies which have come to us through either our ancestors' foolishness or our own . . . While half-alive people think it no wrong to bring into the world human beings with even less vitality than themselves, and take no pains to keep the simplest laws of health, or to teach their children to do so, just so long there will be plenty of sorrow of an avoidable kind, and thousands of shipwrecked, and failing, and inadequate, and useless lives in the fullest sense of the word. (Jewett, 185-86)

Like Rhoda and Dr. Janet, Dr. Leslie seems to believe that people bring about disease and decline through a willful choice—and since ordinary people cannot be trusted to educate themselves, or behave responsibly, the physician must step in and make the right choices instead. Nan herself is a product of faulty genes—mental instability runs in her family—and it is partly for this reason that Dr. Leslie has decided *for* her that she is better suited to medicine than marriage: "looking at her sad inheritance from her mother, and her good inheritances from other quarters, I cannot help feeling that she might be far more unhappy than to take up my [medical] work here" (138). It would not do the race any good for her to marry and have faulty children of her own, but she can help improve the race through the practice of her natural medical abilities.

Racial improvement, as we have seen, was also of further interest, or use, to feminists, since the issue fed into and validated women's claims to authority by virtue of their natural ability to lead through mothering in both the private and public domains:

> Feminists were able to utilize the accepted Victorian reverence for the sacredness of motherhood and raise it to the level of national and racial duty. Thus maternity, a heretofore private domestic function, acquired a set of significances that transcended the merely public. Racial responsibility was interpreted as the highest form of national responsibility. By appropriating it in the name of female emancipation, Victorian feminists committed . . . women and the women's movement to the service of . . . national and racial ideals. (Burton 49)

That so many women doctors, fictional or otherwise, believe in the need for moral therapy in the shape of eugenics, reminds us again of just how complex the medical woman could be, situated as she was within the now-overlapping positions of feminism, nationalism, and professionalism. The height of the late nineteenth-century medical woman's success owed much to her ability to reconcile her feminist goals with the anxieties of popular, racialist sentiment, and the teachings of empirical science—and it is disturbing to think of the degree to which this feminist accomplishment was influenced by some of the period's other, more sinister ideas.

III. Mothering Everything in Her Path:
The Woman Doctor Polices Sexual Morality

While concern for the future of the race may lurk behind the motivations of many fictional women doctors, medical women are, on the surface at least, more interested in helping to improve the lives of their patients in the present. Again, despite the variety of motives actuating individual medical woman, as a group they still share maternalism as a common means, especially when it comes to imposing help on the lower classes. In these cases, the poor are shown to be essentially honest and well-meaning, and the problems caused by their childish ignorance and prejudice can be solved easily enough by the competence and superior wisdom of the woman doctor as lady and mother. One example of this phenomenon that recurs in several doctress novels involves the woman physician being called in to tend to a young, unwed mother: once the medical woman has taken care of saving the woman's life, she then invariably goes about the business of fixing it.

Phelps' Dr. Zay (*Dr. Zay*, 1882), for instance, becomes further deified in Yorke's eyes when he sees her bring one young woman back from the brink of disgrace through the exercise of saintly compassion, heroic endurance, and womanly nerves of steel. Dr. Zay is first profoundly moved by the plight of her patient, apparently deserted by her erring lover:

> You cannot think how such things affect me. He was perfectly free to marry her. There is nothing too bad for him! I have no mercy for such men,—none! . . . And the women all depend on me so; they think there is nothing beyond my power. Why, she clings to me as if she thought I could undo it all,—could make her what she used to be again! I believe she does. It is more than I can bear.
>
> (138)

But of course, Dr. Zay cannot "undo it all." By 1882, the American medical profession had severely prohibited abortion (not to mention birth control). As Mohr explains, for a combination of monopolistic, "nativist[,] and antifeminist" reasons, the provision of such services were made to seem the debased and immoral province of regular doctors' "irregular rivals" (Mohr, 119). Medical women like Dr. Zay often adhered to mainstream opinions; even if she were not concerned about preserving her professional reputation from associations with those female abortionists who called themselves "doctors," she would likely share the prevalent belief among the profession that abortion was a "logically unjustifiable, and hence immoral" procedure (Mohr, 118).[3]

Even were she to attempt the highly disreputable act of terminating the girl's pregnancy, Dr. Zay could still not restore the girl to a position of moral respectability. Only marriage can accomplish that, no matter how hastily arranged. Thus, when the girl's lover, a lumberjack, nearly drowns, Dr. Zay tirelessly works to resuscitate him, effecting a recovery after his co-workers have given him up for dead. Then, taking advantage of the man's gratitude and weakness, Dr. Zay drags him back to his rural sweetheart and insists on their being married on the spot, the one still bed-ridden, the other still dripping wet:

> "I've got some rights in your life, have I, Jim?"
>
> "Yes, marm. I don't deny you brought me to."
>
> "Do you suppose you were worth *touching*, except that you had it in your miserable power to right a poor wronged girl? Come! Do you?"
>
> "No, marm."
>
> "If you don't marry Molly before I leave this house, every lumberman in Sherman may throw you into the mill-pond,—and some of them will. I'll stand by and see them do it." (147)

To Dr. Zay, Jim's moral irresponsibility has almost a contaminating effect. Nearly drowning is not sufficient to cleanse him, but putting duty ahead of self, on the orders of the morally redoubtable Dr. Zay, is. Dr. Zay here seems to revealing some sympathy with the period's purity campaigns, in which feminist reformers played a large part. As Pivar describes in *Purity Crusade*, one of the shared, central beliefs of both purity campaigners and feminists was that much female suffering and oppression was caused by male sexual incontinence (often fueled by alcohol abuse) and sexist legislation that encouraged, rather than discouraged, such evils as prostitution, venereal disease, and reputaton-destroying seduction. Dr. Zay may well have shared the ideals of real medical women like Elizabeth Blackwell, who placed the blame for moral disease on men, and the duty, and qualification, to eradicate it on women—especially mothers in the domestic sphere, and maternal women doctors in the public sphere (Pivar, 39).

Like Dr. Zay, Annie S. Swan's Elizabeth Glen (*Elizabeth Glen, MB*, and *Mrs. Keith Hamilton, MB*, 1895) becomes involved in similar, though less dramatic, situations on a regular basis. On more than one occasion she recounts to her friend, the narrator, stories where the preservation of the patient's health is almost incidental to her preservation of the heterosexual romantic pair-bond, and thus the health of the community. The details of Elizabeth's medical intervention are glossed over; what receives her attention, and what she presents to her audience as the most meaningful aspect of her medical practice, is the social intervention she performs, paying calls on wayward fiancé(e)s and their families, offering advice and guidance to the couple, and in the end conferring the pair with wedded and parental happiness.

Elizabeth herself admits that her curiosity and resulting intervention are "natural and womanly, though quite unprofessional" (23)—at least by the standards of most male physicians. In one case, for example, Elizabeth scolds a patient for attempting suicide; the young woman fears she has been deserted by her husband, and, pregnant and unable to support herself, takes desperate measures. Elizabeth easily cures the woman of the overdose, and then sets about her moral cure, by first explaining the sinfulness of suicide, and then tracking down the missing husband, and bringing about a happy family reunion. Elizabeth's involvement in the case is less as a physician than as a social worker, a role that would have been disdained by many status-conscious male colleagues. Moreover, the social and moral interest she takes in her cases lies outside the realm of her formal, technical training; but Elizabeth justifies her behaviour with the explanation that she is naturally trained for the extra-medical work by virtue of her womanliness.

As another example, when she realizes that one patient is not ill, but depressed because her husband neglects her, Elizabeth resolves to talk to both wife and husband to correct the breach in their marriage:

> "So like a woman," I [the narrator] murmured. "No man doctor would ever have thought of such a thing."
>
> "No, he wouldn't, my dear; you are quite right. I always do my duty by the man doctor, as you call him, but I know very well that it is just in such cases that he makes his professional mistakes. He would have gone on exclusively treating poor little Norah Fleming's body, when the mind was at the bottom of it all the time. It was sympathy she wanted, and mothering, and loving understanding, for she was being worried and neglected into the grave." (132)

Once again, the medical woman proves the worth of, and need for, a woman's touch in the sickroom. Within mainstream medicine, late nineteenth-century male doctors increasingly came to prefer a somaticist methodology, focussing on the patient's body—or just the afflicted body parts—rather than on the mind. As the scientific aspect of medicine began to produce measurable, reliable results, its credibility grew also, and male practitioners eagerly embraced this positive trend: scientific medicine did not simply improve the patient's health, it improved the physician's image as well. While women doctors did not reject the new scientific advances, they still clung to the holistic approach, emphasizing prevention and psychological, as well as physical, wellness, as their special niche—a primary justification for their presence in the profession. As so many of their supporters argued, the woman doctor was not simply as competent as her male colleagues, but was actually more competent when it came to treating the emotional and moral health of the patient. The essentialist thinking that limited so many women to domestic cares, while leaving the realm of pure reason to the men, turns out to give the woman doctor an advantage, broadening the range and power of her medical knowledge in comparison to the more narrowly focussed and, thus, narrow-minded approach of the male physician. Physicians of both sexes are shown in these doctress novels to be equally parentally authoritative, but only the medical woman can effectively treat diseases of the heart and soul by virtue of her capacity for "sympathy . . . and mothering, and loving understanding."

The realization of this apparently essential truth has similar significance for Margaret Todd's Mona Maclean (*Mona Maclean, Medical Student,* 1898)—and, as in the other doctress novels, it is meant to have equal significance for the readers as well. The novel deliberately ensures that only good comes of Mona's involvement in any case to which she turns her hand—and the opportunity to help others also provides the novel with the opportunity to propagandize about medical women as admirable, and vitally essential, role models. As she cares for some of the young women in the local village, Mona (and through her, the reader) is struck by how great the need is for women doctors to act as protectors of their sisters, medically and morally. There is no separation between the two for Mona. Despite her ability to be common-sensical and scientifically objective in order to get her medical duties (like dissection) done, her true calling to medicine comes from her desire to offer comfort and, especially, guidance to women who lack her education and wisdom. Moreover, as Mona demonstrates in her dealings with the local girls who frequent her shop, and in her care for poor Maggie, the medical woman's role as guide and advisor is based very much on her assumption that she indeed knows best, that she always knows better than her less-educated, and less refined female clientele.

For example, after Mona has seen one of the local girls walking alone with a man, the girl, Matilda Cookson, tries to get Mona to keep her secret. After all, Matilda—daughter of one of the best families in Borrowness—believes that Mona is only a shop assistant, with neither an interest, nor a right to get involved in her affairs. Matilda is taken aback, therefore, when Mona quietly, but seriously, censors her behaviour: "And don't you mean to be a fine woman—morally a fine woman I mean? . . . [D]o you know how men talk about girls who 'give themselves away,' as they call it?" (215-16). Mona agrees to keep Matilda's secret if the younger woman agrees to respect herself. Mona never states any opinion one way or the other in regards to the purity campaigns of the day; however, her frank advice to Matilda does suggest that at the very least Mona shares the purity campaigners' belief that if male behaviour cannot be controlled (or prosecuted), and if male protection cannot be relied upon, then women must be active in their own defense.

When Mona discovers that Matilda has taken to love affairs largely out of boredom with her conventional life of leisure, Mona offers to teach her German—eventually, Matilda is so impressed with the intellectual and religious leadership that Mona provides, that she decides to follow Mona's example and study medicine. Mona's involvement with Matilda has been completely outside the realm of her medical studies, at least in technical terms; but Mona is everywhere inspired by an instinctive maternal desire to protect and guide which seems not to recognize disciplinary or professional boundaries. As a soon-to-be doctor, and as a lady, she is convinced that hers is not only the obligation, but the right, to order other people's lives according to her own best judgement: "She forgot that she was supposed to be their social inferior, and remembered only that she was a woman, responsible in a greater or less degree for every girl with whom she came in contact" (214).

This sense of duty is further reinforced for Mona—and the readers—when she is called in, not even as a doctor, but as a nurse, to care for an unwed mother who has come home to her remote Scottish village after being ruined in the big city. Maggie's case turns out to be the pivotal moment in Mona's career, as she realizes just how vulnerable women are in the late-nineteenth-century world—particularly in their dealings with men. Although Dudley demonstrates that men can be women's greatest allies, Maggie's experience shows that many other men are simply not to be trusted. In a case like Maggie's, Mona believes, the best source of sympathy and guidance can only come from another woman, especially a medical woman, with her combination of scientific expertise and moral authority.

For Mona, like Dr. Zay and Elizabeth Glen, is not just a woman doctor, but a *lady* doctor, a product of the upper middle class. And as ladies, all three women take for granted the unquestioned superiority of middle-class values; all three assume that their view of moral conduct supersedes any choices made by their rustic and ignorant sisters. Dr. Zay's case is not successfully concluded until her two patients are married, and their child made legitimate; the same goes for Elizabeth; and for Mona, while marriage is an impossible cure for young Maggie because of the utter rascality of her seducer, forgiveness is not. Morality in Maggie's community is harsh, demanding that the people cast out the fallen woman—as they have no doubt been taught by their middle-class vicars that such sins must be punished and never condoned. But Mona knows better; motivated by a more enlightened sense of Christian charity and women's rights, she lectures Maggie's mother Jenny relentlessly, until the latter is browbeaten into forgiving her wayward daughter.

Mona further smoothes the way by making sure that Maggie's respectability can be eventually restored, again through the intervention and better wisdom of others: "She must not stay here, of course, but if you will let me, I will find a home for her where she will be carefully trained; and you will live yet to see her with a husband of her own to take care of her, and little children, of whom you will be proud" (340). Mona does not condemn Maggie, as her mother is quick to do; she realizes that treating Maggie like a fallen woman is unfair and unproductive. But while Mona can see Maggie as a victim of male predation, she does not seem able to absolve the girl of all responsibility. The fact that Mona sees a need to prescribe rehabilitation—"careful training"—suggests that she suspects that a defect in Maggie's character led her into danger. Again, when men cannot be counted on for sexual purity, it is women's burden and responsibility to insist upon it. But a lower-class girl like Maggie cannot be expected to have learned this concept as part of her natural development, the way a lady might—she must be instructed, and it is women like Mona who must perform this valuable educative work. The relationship between Jenny and Maggie is not their business, as far as Mona is concerned, but hers; Jenny is no more carefully trained than her daughter, and so the two cannot be left to resolve their conflict as they see fit, but must be guided—corrected—by Mona's superior knowledge, and superior moral authority.

Mona, Elizabeth, and Dr. Zay seem to feel genuine compassion for their lower-class patients, and their interference in the non-medical aspects of their patients' lives seems motivated by the best of intentions. Nevertheless, there is an unmistakable element of class bias present in their handling of their separate cases that indicates a paternalistic—or maternalistic—insistence on controlling the moral choices of the lower classes on the assumption that they are too childish to decide properly for the good of themselves, their communities, or the nation. The doctress, according to this vision of her, may be dedicated whole-heartedly to reforming woman's role in society, but her interest in reforming the structure of society itself is indifferent, or at least, uneven. The lady doctor willingly promotes education and improved living conditions for the lower classes, but she seems not to perceive any need to remove the barriers that keep those classes low, subject to her middle-class, professional authority in both medical and moral matters. There is an uncritical acceptance in these novels that society is inevitably ordered according to divisions of class and gender—and the medical woman is portrayed as being an expert in maintaining these divisions through her ethos of scientific motherhood. These doctress novels vigorously promote the cause of the medical woman, taking every opportunity to showcase not only her professional, but her womanly moral talents as well. The aim is show the value of the medical woman's ability to bring motherhood to the masses through science, with an emphasis on the combination of *scientific motherhood*; however, because the writers are unable to see past the most essentialist concepts of gender, the novels end up privileging motherhood over science as the medical woman's strongest value. The effect may have been reassuring to late-Victorian readers, but it may also have contributed to limited expectations about women doctor's professional opportunities.

IV. Medical Women Fight Contagious Diseases of Both the Physical and MoralVariety

The medical woman's interest in monitoring and correcting the medical-moral health of the lower classes is in one sense an issue of maintaining the security of class barriers for the good of the white, English-speaking race as a whole, and for the good of the middle-class especially. At the same time, however, the divisions between classes are in many ways dependent on the division between genders, maintained through the monitoring and correction of sexual behaviour generally, among all classes. When Dr. Zay or Elizabeth Glen, for example, insist on marriages in the case of accidental pregnancy, their exercise of medical, maternal, and moral authority is justified on the grounds that they know best about restoring social order. But the lesson for their patients is not simply about the proper order of class relations, where healthy citizens can only be successfully raised by married parents who respect the laws of the church, the state, and the middle-class lady. As I have already suggested, it is also very much about the proper order of sexual relations, where an unavoidable sexual double standard based on upholding the moral purity of women holds sway.

For much of the nineteenth century, middle-class women were held up as the guardians of the sexual and moral economy upon which social order was believed to depend; the burden of virtue—namely, sexual purity—was made their responsibility, and made acceptable by being romanticized into a noble privilege, and medicalized into a biological necessity (Matus, 57-58). But by the latter half of the century, many feminist groups began to challenge this un-asked-for obligation; they did not question that it was women's duty to preserve society, and the race itself, through purity and morality, but they did begin to wonder why men were not sharing in the responsibility. It was not of much use for women to be pure inside their own domestic sphere, when men were seemingly free to do as they liked outside, and then bring the resulting corruption home, figuratively and literally. Although what came to be known as purity campaigns were ultimately concerned with the control of all vice—alcoholism, gambling, intemperate and self-indulgent modes of eating, dress, and activity—what drew feminists in initially and most compellingly was the specific problem of sexual incontinence on the part of men. While women—of all classes, but especially those of the middle-class—were expected, required, to maintain sexual fidelity and moderation, society seemed to look the other way when it came to male sexual excess. The results were prostitution, venereal disease, and the seduction of innocent girls who had no legal or social recourse once their most valuable possession—their reputations—were sullied.

To begin to right this injustice—to enforce male responsibility while giving women greater power to protect their own rights—was extremely difficult for feminists. As long as the sexual double standard was portrayed as a private matter affecting individuals, to discuss the role of sexuality was to venture into territory deemed too intimate and taboo for public discourse. Men were able to use this situation in order to evade the issue altogether, using arguments which may have been logically flawed, but which also reduced the sexual content to properly decent, vague, terms. For feminists to argue with men on such terms was pointless; and yet, to be more precise and logical was to violate their own lady-like standards of propriety and modesty, which would in turn give their male (and sometimes female) opponents ammunition to discredit them. Nevertheless, feminists eventually overcame their reticence, outraged into plain speaking by the catalyst of the Contagious Diseases (CD) Acts. The CD Acts were an unmistakable instance of the sexual double standard, and by elevating the problem to a matter of government-enforced, *public* policy, they also gave feminists and purity campaigners the chance to draw sexuality out of the silence of the private realm.

Prompted by concerns about the growing numbers of soldiers and sailors infected with sexually transmitted diseases—supposedly by contact with infected prostitutes—the British government implemented the Contagious Diseases Acts in 1864, '66 and '69; in the US, various state governments began to campaign for the introduction of similar "reglementation." The CD Acts were designed not to limit prostitution directly, but to clean it up, by regular, enforced examinations and treatment of women of ill repute. If found to be infected, a prostitute would have to submit to treatment in an authorized facility—the infamous lock hospitals—or face jail time. While recovering at the hospital, she would also be subjected to moral therapy, taught to keep herself clean, to speak and act with respect towards her betters, and to improve both her domestic skills and her sense of religious duty. Ideally, rather than return to the streets, she would emerge from the lock hospital physically and morally fit for more acceptable work, like domestic service.[4]

This aspect of the CD Acts was acceptable to most middle-class observers, who at first did not experience any qualms about holding female prostitutes solely responsible for their customers' lust, or resultant moral and physical contamination; nor did they seem to be bothered by the violations of the lower-class women's civil liberties. Rather, what eventually made the CD Acts into a controversy, and a feminist rallying point, was their clause empowering police and medical authorities to *forcibly* inspect anyone who was, in their judgement, a prostitute. Stories began to emerge of women being arrested, kept in jail, and subjected to the violence and humiliation of being examined with the newest gynaecological instrument, the speculum, all at the hands of "men, men, only men" (Butler, "Third Letter from Mrs. Butler," 79). Occasionally, even innocent ladies were harassed in this fashion; but feminists were also appalled by the treatment of prostitutes: it did not seem fair that male authorities were willing to treat these women as criminals while ignoring the men who encouraged the sex trade:

> It is unjust to punish the sex who are the victims of a vice, and leave unpunished the sex who are the main cause, both of the vice and its dreaded consequences; and we consider that liability to arrest, forced surgical examination, and (where this is resisted) imprisonment with hard labour, to which these Acts subject women, are punishments of the most degrading kind . . . [B]y such a system, the path of evil is made more easy to our sons, and to the whole of the youth of England; inasmuch as moral restraint is withdrawn the moment the State recognizes, and provides convenience for, the practice of a vice which it thereby declares to be necessary and

> venial. (Butler, "The Ladies' Appeal and Protest Against the Contagious Diseases Acts," 11)

Although feminists had been able to point to a variety of sexist injustices over the years, including the denial of suffrage, and unequal marriage and property laws, the details of the Contagious Diseases Acts came as a something of a shock. To many feminists, most notably Josephine Butler, this, more than any other example of sexual bias, proved that the separate spheres doctrine that was supposed to protect and exalt middle-class women, in fact made them into second-class citizens whose idealized purity, modesty, and moral superiority could all be stripped away on the say-so of male strangers with the backing of British law behind them. Women who had previously accepted the terms of Victorian sexual relations were now led to rethink their position, and Josephine Butler's movement to repeal the CD Acts began to attract large numbers of female (and male) supporters who had hitherto avoided any involvement in women's political issues. Butler and her followers made a direct attack on the male hypocrisy behind the Acts, refusing to allow their own ingrained delicacy and reticence to be used to silence or dismiss them:

> When men, of all ranks, thus band themselves together for an end deeply concerning women, and place themselves like a thick, impenetrable wall between women and women, and forbid the one class of women entrance into the presence of the other, the weak, outraged class, it is time that women should arise and demand their most sacred rights in regard to their sisters. (Butler, "Third Letter from Mrs. Butler," 79)

Repeal campaigners would appear on stage brandishing a speculum and explain, in unmistakably anatomical terms, what its role was in the enforcement of the Acts (Walkowitz, 109). Their opponents labelled female repealers as particularly scandalous members of the "shrieking sisterhood" and adopted a lofty and euphemistic tone in their rebuttals; but the plain speaking of women like Butler prevailed, setting the tone for ensuing feminist discourse, and making it increasingly acceptable for women to begin speaking openly and directly about all varieties of experience.

In this regard, Butler's brand of feminism gave her much in common with medical women, who also believed that much immorality and nastiness was often disguised by the hypocrisy of false modesty, and that frankness and accuracy could never be immoral if motivated by noble purposes. Butler could count on medical women to speak as plainly as herself on the subject of the CD Acts if the occasion arose. Butler looked to medical women to unite in calling for a repeal of the Acts, expecting that they would eagerly use the controversy as more proof of the need for women doctors. Many women came through, especially among female physicians in America, most notably Elizabeth Blackwell. They agreed with Butler (and in the US, with Elizabeth Cady Stanton and Susan B. Anthony) that instead of putting all the blame on the marginalized figure of the prostitute, it was necessary to bring the problem closer to home:

> . . . during my past life and medical experiences I had never fully realised the wide bearing on this subject and the inevitable social degradation produced by a double standard of morality. My eyes were now suddenly opened, never to be closed again, to that direful purchase of women which is really the greatest obstacle to the progress of the race. (Blackwell, *Pioneer Work for Women,* 195)

To Blackwell, as Pivar notes, the Contagious Diseases controversy was only a symptom of a larger moral malady affecting society, that could only be cured by a combination of scientific and spiritual therapy. Blackwell was a champion of the growing purity campaign's belief in physical and moral hygiene—and believed that women had a natural and vital role to play in carrying out this dual treatment, especially as doctors: "Blackwell worked for a redefinition of women's reform roles. Within their homes, they had always been reformers, but Elizabeth Blackwell projected these traditional roles into general society" (Pivar, 39). In terms of the CD Acts, Blackwell, and other women doctors who sympathized with the repealers, shared in the latter's argument that men, as allegedly civilized beings, could be expected to exercise self-control, especially since they were no doubt at least partly, if not entirely to blame for spreading disease, not only to women only trying to make a living, but to unsuspecting wives as well. And, like Butler, medical women like Blackwell also believed that enforcing of the CD Acts could be insensitive at best, nothing short of instrumental rape at worst; and that, moreover, such humiliating gynaecological experiences were not limited only to those women victimized by the acts, that such were the typical experiences for all women forced to turn to coarse and poorly trained men for their medical needs.

But the opinion of medical women as a group was divided on the issue. Many women doctors, especially in Britain, did not share Blackwell's blend of religion with science, siding instead with the rationalist, or materialist, male members of the profession who supported the acts. To Butler's great disappointment, both Elizabeth Garrett Anderson and Sophia Jex-Blake took the latter view. Anderson, always the more careful, restrained, and thus more credible counterpart to Jex-Blake's more impassioned outspokenness, had to admit that she saw no better solution for controlling the spread of venereal disease. Like many of her medical colleagues, she seems to have accepted the popular assumption that the disease was spread by prostitutes, and that since controlling male lust seemed unlikely, it would be better for physicians to focus their efforts on helping, and hopefully rehabilitating, the afflicted women. Jex-Blake, who so often disagreed with Anderson on other issues, seemed to share her position on this one.

Anderson's and Jex-Blake's reluctance to support Butler's arguments about the facts of life makes the former, along with other like-minded colleagues, appear to be in unscientific denial. But as biographers Jo Manton and Shirley Roberts suggest in their defense, the height of the CD Acts controversy occurred while the medical women's movement in Britain was still finding its legs. At the time Anderson was still just starting out on her career, and Jex-Blake had yet to win professional credentials of her own, let alone professional credibility. These pioneer medical women had to be careful about where they positioned themselves on any controversial issue, or risk losing their more conservative supporters. This was a dilemma faced by many pioneers in women's education and professionalization. A prime example was feminist disagreement over suffrage throughout the late nineteenth and early twentieth centuries; women as diverse as Emily Davies (England) and Annie Nathan Meyer (US) deliberately distanced themselves from the suffrage movement for fear that the public suspicion of that issue would spread to all feminist causes. Similarly, for Anderson and Jex-Blake, when forced to choose between causes, they chose to put women's medical education and professionalization ahead of a political issue that may have seemed to them to be comparatively minor, or just too dangerous.

Moreover, their position should remind us once again of the fact that the woman doctor, like any individual, never belongs to just one interest group. Anderson and Jex-Blake were ladies of the upper middle class, medical professionals, and feminist sympathizers—it is hardly surprising if one set of loyalties won out over others in this instance. In the case of the CD Acts, many women doctors believed that the best way to serve the cause of women in general, and medical women in particular, was through an allegiance to the profession in which they had immersed themselves. Many physicians of both genders were baffled and frustrated as they observed the lay public swayed by what seemed to be the scare tactics of uninformed reactionaries who would paint the medical profession with one large, vivisection-, abortion-, and lock-hospital-tainted brush. Popular medical opinion found the CD Acts a good practice of public hygiene, and regarded examination by speculum as a relatively benign procedure rather than a deliberately vicious means of violence towards women. Perhaps this view was perfectly valid, or perfectly dangerous; nevertheless, working without the support of some of the more potentially influential medical allies, Butler's campaign of outrage and indignation, combined with infection rates that refused to go down, led to the repeal of the Acts in 1886 in Britain. In

America, reglementation legislation was similarly defeated by Anthony and Stanton's protest movement .

And what was the position of the fictional medical woman throughout this controversy? Apparently, she had none: despite the fact that real women doctors were called upon to involve themselves in the issue, the subject is virtually non-existent in the doctress novel, except through the most oblique and side-long references. The absence of this controversial issue, I would argue, is further evidence of the larger strategy employed by the novels' authors to legitimize the doctress' reassuring womanliness. At the same time, however, the novels' unwillingness to engage with the full range of moral and professional challenges faced by real medical women demonstrates the essentialist constraints inherent in this approach. By limiting what the novels can say, their authors limit what their doctress protagonists can do as role models for social change.

Moreover, that the doctress novels so scrupulously avoid mentioning the CD Acts in any direct way cannot simply be ascribed to Victorian prudery. In both the popular press and in other fictional works, authors and their readers were confronting a variety of issues surrounding sexuality and the medical profession's position on morality: the Contagious Diseases controversy was only one aspect of a larger concern among many observers about the dehumanizing effects of scientific method taken to the extreme. Many writers who may not have agreed on other issues, like female emancipation, found a common cause in their focus on medical-moral issues. For many, the CD Acts were not simply the result of masculine insensitivity and hypocrisy towards women. Rather, they were seen as an inevitable part of a continuum of medically sanctioned cruelty and amorality that was responsible for the exploitation of all its research subjects: women, poor hospital patients, and animals were all being tortured and experimented upon by a medical profession that was out of control.

For example, Edward Burdoe, under the pseudonym Aesculapius Scalpel, wrote two novels about a fictional teaching hospital, *St. Bernard's: The Romance of a Medical*

School (1887) and *Dying Scientifically: The Key to St. Bernard's* (1888). In the first novel, his heroic protagonist Elsworth becomes gradually repulsed with modern medicine as it is taught at St. Bernard's; the male medical students are coarse and cruel, and the professors are worse, many of them actively involved in the most brutal human and animal experimentation. The novel's critique of the medical establishment echoes many of the arguments made by female practitioners in favour of medical women as a morally uplifting antidote. However, Burdoe's one medical woman is demoted to the status of a saintly nurse, Sister Agnes, who becomes a partner to Dr. Elsworth both romantically and medically as they work to bring compassion, common-sense, and humility back to their profession. At the same time, Burdoe makes his critique of medical corruption and arrogance quite explicit. The narrator editorializes at length, with detailed examples, on the evils ensuing when medical men put science ahead of their humanity:

> It was this same [Dr.] Wilson who so horrified Elsworth by compelling him to tear off the thumb-nail of a patient for whom such an operation was necessary, without the use of any anaesthetic. "If we gave chloroform for every trifling job like that," he said, "we should have enough to do." He had become so case-hardened against feeling pain in others that he could only attribute to weakness and incompetence that hesitation to cause a single unnecessary pang in any sentient being which is the unvarying qualification of all the greatest and noblest men and women of whom we know anything. The blood-madness of some of the Dukes of Milan no doubt began early with unrestricted torture of animals. Not all at once do men bring themselves to hunt their prisoners with dogs fed on human flesh . . . . (156)

In the novel, such harsh treatment of patients leads to vivisection, which in turn leads to homicide, as the villain of the piece becomes progressively degraded by his absorption in heartless science.

Sarah Grand's *The Beth Book* is also notably frank in its critique of the male medical profession, this time from a decidedly feminist perspective. Beth's husband is an amalgam of all that many feminists saw as the most problematic masculine qualities. Dr. Daniel Maclure mistreats Beth emotionally, by blatantly carrying on an affair, by interfering in her own beloved creative pursuits, and by denying her any say in the couple's finances. But what most repels Beth and eventually drives her to leave Maclure is, first, her discovery that he works in a lock hospital, and cheerfully oppresses the women unjustly incarcerated there, and second, that he is also a vivisectionist, practising cruel experiments in their own home, on a little puppy that Beth had assumed to be her pet. When Beth's husband argues that "[t]hese experiments must be made, in the interests of suffering humanity, more's the pity," Beth retorts that the experiments are only made "[i]n the interests of cruel and ambitious scientific men, struggling to outstrip each other, and make money, and win fame for themselves regardless of the cost" (440). Clearly, Grand has no reservations about airing her views on the troubled relationship between feminism and what she sees as the worst elements of a specifically masculinized science.

In fact, many writers like Grand and Burdoe found that their political and moral expression was not at all constrained by their choice of the novel as a medium. In the later nineteenth century, fiction was beginning to emerge from Mrs. Grundy's control of the lending libraries and their complicitous publishers, and the novel was seen by many as an ideal medium for political expression and propagandizing. And indeed, the authors of the doctress novels were no different than Grand or Burdoe in using fiction as a persuasive vehicle. However, while the doctress novels may not have been prevented, at least in theory, from being more explicit about involving their medical protagonists in some of the more controversial medical-moral issues of the day, the authors of these works, like the real-life medical women who served as their models, were bound by political concerns and loyalties that did impose limitations on which conflicts could, or could not, be discussed directly.

In general, when the medical woman, or a character close to her, takes a stand on political or moral issues, the viewpoint may sometimes seem extreme or unconventional—but it would rarely be out of touch with views espoused by a reputable number of real-life experts and activists. Dr. Janet's and Rhoda's belief in eugenics, as I have already noted, was actually very much in accord with popular medical thinking—and, increasingly, with feminist thinking as well. Perhaps more significantly, those novels that seem to criticize modern medicine do so very selectively. Their targets are ill-trained, ill-suited medical men who have chosen their profession only out of a desire for profit and self-advancement; medicine itself, including its self-proclaimed authority on all issues moral, political, or scientific, is seen as a tool to be used for the improvement of society, especially in the compassionate hands of medical women like Mona Maclean, and their worthy male partners. Mona is probably the only fictional doctress who even mentions vivisection's controversial role in medical science—and she defends it as a necessary and beneficial scientific practice, as long as it is carried out responsibly and with the proper reverence:

> Physiology is such a floating, growing, mobile science . . . What the physiologist has to do is to plunge his mind like a thermometer into the world of physiological investigation, and register one thing one moment, and another thing the next. He need never carry on experiments on living animals before his students, but he must live in the midst of the growing science—or be a humbug. (191)

Those who condemn such scientific practices, she suggests, do not understand them—a view which echoes Elizabeth Garrett Anderson's own stand on the Contagious Diseases Acts, and which reflects Mary Putnam Jacobi's impatience with Blackwell, and other women, whose rejection of modern scientific practice as a menace is a result of a kind of stereotypically feminine, politicized superstition rather than enquiry through the scientific method.

But while Mona is allowed a passing reference to vivisection—where it seems to be primarily intended to lead the readers to additional respect for Mona as a committed woman of science, rather than a lady-dilettante or a political radical—most of the other doctress novels do not risk even this much contact with real-world controversy. The possibilities for fiction were increasing as publishing practices became more diverse; but for many novelists, the traditional audiences, reached through traditional, established, financially reliable means, still exerted a large influence. For those wishing to reach a large, mainstream audience, a certain degree of cautious conservatism was inevitable.

For example, as we saw in Chapter One, David Finkelstein has documented how Charles Reade made a strategic decision to bow to Blackwood's editorial pressure: in return for gaining access to Blackwood's large readership, where Reade hoped to make a convincing case in favour of medical women, he agreed to tone down some of his more enthusiastic political expressions. Similarly, the fact that *Dr. Edith Romney* was published as a triple-decker in 1883—by which time many historians declare the three-volume novel obsolete—suggests that this particular novel form was still enjoying at least modest success, and with it its unique support structure, the circulating libraries. Such libraries, most notably Mudie's, had long been criticized for their stringent moral code, which insisted that their target reader, the young person, must be protected from any thing too racy or scandalous. Edith Romney's awakening feminist consciousness might have been considered somewhat risqué; for such a novel to go further and take a stand on an issue like contagious diseases—hardly the 'flu, in their context—would be going too far indeed.

Such editorial caution—or, as some would say, censorship—led many writers to pursue alternative means of publication, even if it meant reaching a smaller audience in order to achieve a more complete and frank discussion of issues. However, most of the doctress novels seem to have aimed for the more traditional markets. Perhaps this indicates some inherent conservatism on the part of the novelists—and indeed, as I have already mentioned, the doctress novels do have a tendency to espouse ideas that were, in the long run, supportive of the middle-class status quo. However, the doctress figure is, by her very nature, a controversial one, suggesting that the novels' authors were trying to accomplish something more, in most cases, than mere novelty, that they were deliberately attempting to propagandize through their portrayals of their medical women.

My reading of these novels has led me to conclude that their almost total silence on such inflammatory issues as the CD Acts or vivisection was motivated by the same strategic desire to maintain a distance from controversy evidenced by real-life medical women like Elizabeth Garrett Anderson. As a result, the doctress novels are very careful not to overload their readers with more political content than was palatable, or safe. The majority of the doctress novels are committed primarily to one cause, that of promoting the claims of women to medical and professional authority. In order to persuade a mainstream readership to accept the medical woman as a valid novel and romantic heroine, she must be rendered as non-controversial as possible—she must be made to appear as a contributor to middle class interests for class, race, and gender harmony through hierarchy rather than as a threat to it. Consequently, any radical opinions she may have must be ones that have already been absorbed, to a certain extent, into mainstream culture. On the one hand, the medical woman in fiction is often portrayed as a moral leader with purity campaign values, who can guide weak or fallen women out of sexual danger. On the other hand, I would suggest, too much comfort discussing *specific* issues of sexual morality could indicate an unwomanly level of knowledge and sympathy for the wrong parties. And since when it came to the CD Acts the question of who, exactly, was being wronged was very much part of the debate, it was better to remain silent. Unless a social issue could be introduced in such a way as to enhance the womanliness of the doctress, it was not introduced at all.

So, for example, the closest that many novels could come to addressing the Contagious Diseases Acts was to try to deal, rather obliquely, with their underlying issues, namely the problem of irresponsible male lust. In the doctress novels, however, this does not result in a confrontation of prostitution. Rather, the issue is diluted somewhat, into episodes featuring simple, good-hearted lower-class girls—the woman doctor herself is never in any sexual or moral danger—who are seduced and then left, or who surrender their virtue willingly enough only to discover their lovers have taken advantage of them. It is then the job of the medical woman to shame the offending males—either in absentia, by making them look all the more despicable in comparison to the sympathy and compassion the woman doctor possesses, and convinces everyone involved in the case to share (for example, Mona Maclean's moral coercion of Jenny to forgive Maggie); or by brow-beating them into behaving like decent, contributing members of society, by marrying the unwed girls and starting legitimate families, for better or worse. Through sheer force of womanly personality, the doctress imposes social harmony and middle-class morality wherever she goes. Even though she is venturing into dangerous waters by even coming in contact with sexual sins, she emerges from the experience all the more morally pure and dedicated to safeguarding the physical and moral health of women everywhere—and, as a bonus, making the medical woman appear not only acceptable, but essential, as an agent in the maintenance of social stability.

The only novel that I have found which comes close to direct confrontation with the contagious diseases issue is Annie Nathan Meyer's *Helen Brent MD* (1892). But even here, the controversy is defused somewhat by a layer of carefully-worded, polite narrative which buffers the medical woman from too close an involvement with dangerous subject matter. *Helen Brent MD* takes place in New York, about six years after the CD Acts were repealed in Britain and defeated as legislation in the US. The anti-reglementation protests in America had built on the organizational momentum generated by the women's movement's involvement in abolition (the new cause of protest against contagious diseases legislation was even known as the "New Abolition"). After the contagious diseases protests, many feminists continued to work for related causes such as campaigns for sexual purity, temperance, and what was known as "apocalyptic feminism": "the belief that the moral superiority of woman gives her a leading role in the imminent establishment of a more perfect world" (Helsinger, Sheets, and Veeder, II: 160).

In this climate, American medical women were as deeply involved as, if not more than, their British counterparts in the negotiation of the medical profession's claims to moral, as well as medical, authority. Nevertheless, for fictional doctors, engagement with these issues was still hampered by conflicting obligations to publishing standards and propaganda. Consequently, *Helen Brent* presents a very unusual case in that the novel seems to deal openly with a variety of medical moral issues, including sexual ones; although the novel still handles this subject area delicately, it is nevertheless very frank when compared to other doctress novels of the day. *Helen Brent* is actually one of the most overtly propagandistic of the doctress novels: plot and character development are dealt with expeditiously as a means of leaving most of the text to be filled with Helen's opinions, elicited through carefully engineered conversations with other characters, on the subjects of feminism, medicine as a career for women, marriage, and physical and moral health for young women.

Helen's feminism is of an unsentimental variety (Meyer, 49); while a staunch defender of women's rights she is also heavily influenced by her scientific training and, like Mary Putnam Jacobi, she refuses to separate the cause of woman from common sense.[5] For example, she causes a mild scandal in New York feminist circles when she is appointed the director of a new women's hospital. She has been chosen to lead and serve as a role model for women medical students because of her medical abilities and her commitment to proving women's ability to take on men's work; and yet one of her first actions is to hire a faculty that is almost entirely male. She refuses to practise affirmative action simply for its own sake, and believes that it is more important to provide the women students with the best instruction, even if the best instructors, at the time, and in her opinion, are men. Helen is not a professional feminist who also happens to be a doctor; she is a medical professional who also happens to be a feminist. As a result of having adopted the habitus of the medical profession, her primary goal is good science, rather than correct politics:

> I am almost afraid to say it, for I naturally want my heroine to be popular, but I suspect Helen was really more interested in the fact that the Root Memorial Hospital and College would advance the condition of medical preparation all over the country, in the fact that it encouraged original research, and inculcated the love of science, for science's sake, not for breadwinning only; I suspect very strongly that she cared more for the Root Memorial because it accomplished all this, than (dare I breathe it?) merely because it was another college open to women without restrictions. (50)

Helen's multifaceted identity as woman, doctor, and feminist interferes with a variety of relationships with both sexes. As Edith Romney discovered, owing allegiance to many social roles makes it difficult to meet the expectations of those with allegiance to few. Like Edith, Helen finds that feminists accuse her of not being committed enough to equality, while conventional, non-activist women find her many social and political opinions threatening and alienating. And Helen herself, made into something more than simply a lady by virtue of her "masculine," scientific education, finds most women equally baffling in turn; she is frustrated with their complacent acceptance of their stereotyped social role, based on passivity and ignorance. She is driven almost to depression by the behaviour of the "ladies" she meets socially and professionally. As social leaders, these women have more power than they realize to alter codes of moral and physical behaviour, and yet they are stolidly resistant to change, preferring blindly to perpetuate a social system that literally drives people to ruin their moral and physical health.

But while Helen is deeply distressed about women's inconsistent and thoughtless treatment of one another, her main concern throughout the novel is with the current state of sexual relations between men and women, both in, and importantly, out of, marriage. As I pointed out in Chapter Two, Helen believes passionately in a new ideal for sexual relations, where man and woman come together as equals, respectful of one another's interests as individuals, rather than as indistinguishable conformists to a corrupt social system. Helen accepts the need for women to be the primary care-givers of children—from a scientific and feminist standpoint, she believes that motherhood is the natural role of woman; but she also refuses to believe that motherhood is incompatible with other personal and professional goals within the modern family. To her, the man is not the only one to have a well-rounded life, and in fact, nothing can be worse for a relationship than to divide it into the traditionally separate spheres where the woman is almost trapped at home, while the man roams about the public domain. In such a relationship, the man is allowed to develop and grow while the woman's development is stunted, arrested, even reversed, fulfilling society's expectations of female childishness.

Helen sees such marriages everywhere, and is depressed and repelled by the women they produce. When Harold Skidmore proposes to her, but only on his own terms, she forces herself to resist the temptation to take a brief period of romantic happiness in exchange for the same dismal fate awaiting so many other women. And Helen has gauged the situation well—as Harold's career keeps him increasingly out of the home, his relationship with his new wife rapidly deteriorates, until the two become virtual strangers to one another. The wife, Louise, a conventional young woman with conventionally weak moral fortitude, eventually looks for comfort elsewhere, with a man known for seduction and adultery—and whose venereal infections have already resulted in death, illness, and shame for at least two of Helen's own young female patients.

Inevitably, Harold's wife also ends up pregnant, and nearly dies from complications—and the suggestion is that the complications are a result of infection from Verplanck, her lover. Helen, called in to manage the case, feels pressured to be very selective in her description of the diagnosis that she gives to Harold. Helen does not want Harold to learn the truth about his wife through the vicious rumours of society; but although the rumours are the only proof that Harold could accept, they would also scandalize and devastate him. Feeling herself to be in an impossible situation, Helen cannot bring herself to speak frankly to him about his wife's true illness. Nor can she warn anyone else; even as the infected Verplank moves on to new conquests, the genteel and fashionable world in which he operates is shown by the narrative to be completely beyond the reach of moral reason:

> Here in the hospital now lay a woman whose future was utterly wrecked, whose physical condition was utterly ruined, who, if possibly spared to life, would have no future, no outlook, who would be shunned and pitied (that would be far too mild a word), and the father of her child, where was he? No doubt sitting at this moment in one of the most elegant houses on Fifth Avenue, his arms about a young girl, who was about to unite her fresh, innocent life with his, who yet would have shrunk in horror and disgust from this poor, ruined woman. And what could Dr. Brent do? What could she accomplish, single-handed, against the whole world? Suppose she were to stand on the housetops and proclaim the story to all. What would that world say? Why, merely that it was very poor taste in Dr. Brent to say all this . . . . (73-74)

But the fashionable society *doyennes* of this novel are not Helen's main audience, reform-minded readers are. And to them, through her own private thoughts as the narrator relates them to the reader, Helen can be more forthright. In her view, individual women are needlessly victimized by the "cruelty of the social structure of morals" (73), which emphasizes marriage for its own sake, as a means of maintaining stability both socially and economically, rather than for genuine compatibility between equals. And yet women are also partly to blame, since, as social arbiters, they fail to make use of their power to combat hypocrisy and immorality. Instead they allow themselves to be corrupted by the system, turning a blind eye to its flaws, and turning their backs on its victims, except to gain entertainment from the scandal: "I claim that if the world would frown on peccadilloes, as [society] calls them, many a vain woman would pause and go no further. As it is now, society, with its smiles and bows up to the last moment of endurance, only smoothes the way down to the lowest pit of shame" (190). However, as Helen sees it, women cannot be held entirely responsible. Men are also in dire need of reform and education; until they see women as equal companions, rather than merely the symbols of status, and the mechanics for their household machinery, they will not be able to inspire fidelity in their wives, or practise it themselves. Venereal disease, the evidence of this resultant illicit sexual activity, is the inevitable symptom of a more profound malignancy at the heart of late nineteenth-century sexual relations.

In the novel, Helen Brent cannot speak with complete candour about the consequences of sexual infidelity, as she would if she were a real-life medical woman writing in the popular, or feminist presses. However, in an important way, she does not need to be frank about sexually transmitted diseases, because her purpose is not to discuss the technical aspects of this one symptom from a purely scientific standpoint. Rather, her aim is to talk frankly about the problems of modern marriage, and modern society generally. Despite Helen's claims to put scientific medicine first, her primary role in the novel is to promote moral therapy. As a medical woman, she has been authorized by the novel to employ her professional expertise on a moral issue, which she can discuss with the readers in depth. Science, in this propagandistic narrative, has become almost a subsidiary of morality; and the medical woman, as a medical expert, demonstrates her knowledge through her powers to diagnose and prescribe for moral problems, more than physical ones. Sexual activity, the novel implies, is enjoyed by both men and women—an unusually advanced position—but the novel goes beyond implication to direct commentary on the more vital issue of moral activity.

As a doctress novel published late in the form's history, *Helen Brent MD* shows one of the final evolutionary stages of the shift in social and sexual boundaries brought about by feminism, women's medical education, and the rise of the medical profession. As the novel shows, at this point, it is not feminism—with its educated, professional women—that is the threat to social stability, and stable social barriers. Rather, feminism, in tandem with the medical profession's expanded medico-moral purview, has now become the antidote to what is presented as the diseased state of outmoded, irrational, unscientific barriers between the sexes. Feminism, through its offshoots of purity and vigilance, has joined forces with medicine to take on the role of expert in the realms of both physical and moral behaviour—since these are only two sides of the same coin anyway. And if feminist moral authority has been assimilated into medical scientific authority, to posit the medical woman as the agent of a medicalized society, it is only because society, in its weakened, diseased state, is incapable of monitoring its own moral—and thus physical—health.

Helen Brent is portrayed as being rather out of sympathy with other feminist medical women—but, as with the other women doctors discussed in this chapter, although her means may vary, the ends she works for are the same. The overt, propagandistic purpose of the novels is to promote the cause of the medical woman by providing her with ample opportunity to prove both her professional fitness and her womanly, maternal authority. The inadvertent, but no less influential, result of this strategy is to reinforce a belief in the primacy of middle-class values. The doctress novels offer readers a convincing case for the ability of the medical woman to be successfully integrated into a stable, conventional society, by reassuring readers that women doctors are simply building on their natural claim to maternalism in the home by bringing this motherly care into the public realm. However, by relying heavily on the essentialist notions underpinning this "scientific motherhood" the novels contributed to the growing conflation in society of women's naturally-justified rights, and their naturally-circumscribed obligations. As I will explain in the conclusion, medical woman—and feminists generally—were, in this way, attempting to build the castle of future opportunity upon a sandy hill of traditional limitations.

Conclusion:
The Fictional Woman Doctor Faces the Consequences for the Future

Women doctors in late nineteenth-century North America and Britain often became actively involved in all levels of preventative health care, to their credit and to their detriment. On the one hand, the fields of social work, public health inspection and education, immunization, and community-based medicine, owe much of their existence to the pioneer women doctors who made up large numbers of their staff. On the other hand, the reasons for such widespread female involvement in these fields offer yet more evidence of the gender biases operating within the profession at the time, among both male and female doctors. Public health and hygiene were seen to be acceptable and laudable pursuits for the new generations of women doctors, and both men and women seemed able to agree that the emphasis on caring, rather than curing, was best suited to women's inherent nurturing nature.

But as historians like Morantz-Sanchez and Shorter point out, new advances in medical technology and science—namely the development of germ theory, and devices to detect and study germs—were changing the way doctors saw themselves and their patients. The patient's emotional comfort, for example, was coming to be seen as immaterial to the culture and analysis of specimens taken from the patient's body—the impersonal part, rather than the individual whole, was the locus of diagnosis and treatment. Medicine's new masculinist heroism was based on brilliant pathology and daring prescription carried out in the increasingly dominant structure of the large research institution, rather than through the compassionate exercise of wisdom or sympathy conducted on the personal level in the old-fashioned house-call. Consequently, while no-one could deny that an ounce of prevention was truly worth a pound of cure, preventative health care was nevertheless seen as less technically and intellectually demanding, less productive of new scientific knowledge, and so less glamourous, less prestigious, and less lucrative: then, as now, tenements and community clinics could not compete with shiny new pathology labs and hefty government and private grants.

But most women did not pursue a medical career for prestige or profit—as the early pioneers had insisted themselves, medicine was a natural expression of womanly self-sacrifice and service to others. No surprise then that women doctors found themselves persuading others, and persuading themselves, of the truth of this rhetoric, with the result that large numbers of women doctors found public health to be the most congenial meeting point between their scientific and medical interests, and the compelling demands of gendered society. The resulting "feminization" of these related fields left scientific research, surgery, and other "cutting edge" fields of medicine largely to men, and a masculinized medical culture; even today, when nearly 50% of most medical school graduates are female, there is a disproportionate representation of women in the lower-pay, lower-prestige fields of family medicine and community health. But despite the fact that the women doctors in public hygiene were in some ways a doubly-dominated class fraction (low status by virtue of both their gender and their choice of practice), they were nevertheless able to effect great changes among their patients and clients, offering education about cleanliness, pre-, post-natal, and child care, family planning (within the limits of the law), nutrition, and morality.

Women doctors had kept the promises they had made; in exchange for a fair field and no favour, they would use their natural womanly characteristics to enhance medical care, mothering their patients in the public sphere just as they would mother their families in private. The result was success, or so it seemed in the last decades of the nineteenth-century women's medical movement; while other feminist efforts like suffrage met with nothing but frustration until the early twentieth century, women doctors made what seemed like rapid and unprecedented progress. And yet, by the turn of the century, the numbers of women entering medicine began to decline noticeably, a trend that would continue in the US and Britain until the 1960's. According to figures cited by Walsh, for example, women doctors went from making up only 0.4 per cent of the US medical profession in 1860 (approximately 200 out of 55,055 doctors), to 5.6 per cent (7,387 out of 132,002) in 1900, a fourteen-fold increase. But unlike the last four decades of the nineteenth century, the first four decades of the twentieth actually saw a slight decrease in the numbers of medical women: in 1940 women doctors made up only 4.6 per cent of the profession (7,708 out of 165,989) (186).

Historians such as Walsh, Morantz-Sanchez, and Glazer and Slater agree that this decline came about for three main reasons. The first was that feminism in general lost a good deal of its nineteenth-century momentum, partly due to a premature sense of victory as a result of the suffrage victories, and also due to the social stresses surrounding the First and Second World Wars—and without the existence of a cause to rally around, the support networks that had kept many women activists going gradually eroded.

Secondly, male-dominated medical institutions did carry out both deliberate and inadvertent policies designed to exclude women and minorities from equal access to educational and career opportunities. In the first few decades of the twentieth century, medical school enrollments were up; since schools had no particular financial need for women or minority students, their enrollment was either not encouraged, or even prevented by unofficial quota systems. The two world wars created openings for women in schools during the conflicts, but once male soldiers began returning home, women were once again excluded. For women who did make it through medical school, access to hospital internships and medical societies was often limited by pressure from the so-called "old boys"' network. Moreover, women had difficulty establishing an "old girls" network: because hospitals and universities were reluctant to give women senior faculty positions, women students had few mentors or visible role models to follow. And finally, the medical profession one hundred years ago was much as it still is today, making little concession to extra-professional demands such as child-rearing.

But, as the example of earlier pioneer medical women had shown, exclusionist tactics alone could not keep women down, unless combined with the third reason for the medical woman's near defeat: there was a serious flaw embedded within the strategies employed by early women doctors which remained beyond their perception until it was too late, but which guaranteed that the movement would become a victim to its own success. That is, medical women earned their eventual positions of respect in health care by emphasizing the essential womanly—and maternal—qualities of compassion, common sense, and moral authority. But since these qualities were natural to any well-bred middle-class lady, it began to occur to many that they could use their womanliness to serve society just as well in other capacities, without going through the arduous trials of a doctor's education. As a result, many women chose nursing, social work, education, the new and apparently highly scientific fields of home economics, and, by extension, home-making—all professions which were easier to enter, and more compatible with the conventional expectations about female ambition that many medical women themselves had very publicly upheld.

Moreover, medical women had been so convincing in their ability to combine the maternal with the scientific that they ended up convincing themselves and would-be followers of the need to fulfill their biological destiny as protectors of the race—not as doctors, but as mothers. Medical women had capitalized on the one argument about Woman's mission that their male colleagues would not refute, and which indeed brought the otherwise competing sides together. But as Ehrenreich and English point out, the result was that the women doctors had inadvertently given tremendous impetus to the medicalization of motherhood, so that average women, listening to both male and female experts, now came increasingly to believe in their duty to preserve the family and the race by giving up their careers to focus full-time on their children. Women doctors were true to their word; they had vowed to use their womanly powers to bring physical and moral health to society, to impose domestic order in order to maintain social boundaries. In their moral zeal, they came very close to sweeping their own cause under the carpet.

And so the question now, at the conclusion of this study, is this: to what extent did the doctress novel contribute to the rise and near-demise of the female medical professional? Did the existence of these novels affect the cause one way or the other? Did they matter?

While I would not go so far as to claim that these novels were highly influential—their names and authors would not be so forgotten now if they were—I do believe that they played a significant part in the public discourse through which the women's medical movement was negotiated. Theirs were among many voices demanding to be heard, even in spite of their conciliatory tone. While real women doctors like Sophia Jex-Blake or Mary Putnam Jacobi wrote to tell the public about what the medical woman could do, in true narrative fashion the doctress novels were able to show the public what the medical woman could *be*. Whereas the discourse in journals ranging from *The Nineteenth Century* to *The Journal of the American Medical Association* might tend to focus on the abstract issues of rights and characteristics, the doctress novels were able to create representations of women who, despite their unconventional career choices, were still able to be reassuringly and concretely conventional and familiar. The doctress novels downplayed controversy and grisly medical duties, but they played up the woman doctor's competence, intelligence, and resilience—even, in some cases, her ability to combine romance and career with previously unimaginable success. For the young women who probably formed the novels' primary audience, these fictional medical women served, for the most part, as relatively positive role models.

But I do have to qualify that assessment by using the term "relatively." Despite the romantic trappings that tend to obscure the genuinely realistic portrayal of the medical woman, at their core these novels do capture the essence of the debate about women's professionalization. Like their real-life counterparts, they adopt the same strategies of conciliation and compromise, minimizing the woman doctor's potentially controversial aspects, and maximizing her portrayal as a paragon of middle-class domestic virtue put to use in the service of middle-class, imperialist efforts. Consequently, although the novels may have presented the life of the medical woman as an attractive one for their readers, they also tended—again, unwittingly—to reinforce the same limitations that ended up hindering real women professionals as they struggled to leave nineteenth-century thinking behind them. The fictional woman doctor is attractive because she is safe: this is how she may have been made to appeal to the largest possible audience. But while this may have been a practical approach to take at the time—indeed, probably the only approach possible—such a representation would only tend to blend in with the same essentialist thinking that led women away from surgery and research into the lower status work of public health and hygiene, and work whose status was artificially inflated to serve class and racial interests. Again, the fictional woman doctor, like her real life counterpart, was too good at being compassionate, orderly, moral, and maternal. As a result, whether the medical woman practised in public or in private, in real life or in fiction, she impressed others, and herself, with the dangerous notion that women were so good at motherhood, they would not be fit for anything else, for many years to come.

Notes

Introduction

[1] I have chosen to narrow my geographical focus to exclude Europe, partly because I wanted to concentrate on literature in English (rather than literature in translation), but also because the medical women's movement had a very different character outside of Britain and North America. As Kate Campbell Hurd Mead and Sophia Jex-Blake pointed out in their early studies of the history of medical women, European universities, especially those in Italy, had accepted selected female medical students for centuries. In the nineteenth century, several countries were known for their tolerance of women doctors, notably Russia, Switzerland, and France. English commentators would view this phenomenon as an example either of foreign male chivalry, or as an example of how degraded a given nation's civilization really was, compared to England's—the argument being that, unlike pure English girls, foreign girls were allowed to do anything, and it was therefore no wonder that foreign culture was so inferior. Nevertheless, the medical schools in Paris especially were regarded as the most scientifically advanced in the world for most of the nineteenth century, and British or American women who were forced to study in France often ended up with a medical education superior to anything they could have received at home if their countrymen had allowed it. Women medical students also found themselves well received at European universities; from their reports, it seems that the male medical and academic profession in Europe was secure enough to tolerate the novelty of women doctors without feeling economically or sexually threatened.

[2] Rachel Blau duPlessis theorizes about the limitations of the traditional marriage plot in her *Reading Beyond the Ending: Narrative Strategies of Twentieth-Century Women Writers*. Nancy Armstrong defines and analyses domestic fiction in her very useful, very influential *Desire and Domestic Fiction: A Political History of the Novel*.

[3] Two reviews that do stand out are Sophia Jex-Blake's "Medical Women in Fiction" and Hilda Gregg's (aka Sydney Grier) "The Medical Woman in Fiction." Each of these reviews is a survey of the doctress novels as a group, and both consider the degree to which each novel supports or undermines the cause of medical women. Jex-Blake's also takes a professional interest, assessing the degree of medical realism in each; she concludes that only one does a very good job of representing the real experiences of a medical woman—interestingly enough, her choice is *Mona Maclean, Medical Student*, one of the most popular novels in the group (running to at least thirteen editions), and written by none other than Jex-Blake's close companion, Dr. Margaret Todd.

Apparently book publishers have always been extremely cagey about releasing their sales figures, a problem that becomes exacerbated by the loss of records (or the absence of comprehensive indices with which to organize a search) over time. Simply trying to find the doctress novels themselves can be a very difficult task: aside from those that are conveniently entitled "Dr. Obviously-female-name," there are no stand-out titles to guide researchers; many of the novels (and who-knows-how-many short stories) were written by unknown authors, often writing pseudonymously or anonymously; and there are no comprehensive, annotated *subject* indices to help researchers along either.

[4] For more information about women writers and propaganda novels or the novel with a purpose see Constance D. Harsh's *Subversive Heroines: Feminist Resolutions of Social Crisis in the Condition of England Novel.*

[5] A prime example of the way modern biases and presuppositions can lead to an inaccurate, and sometimes unfair, reading of the past is pointed out in Regina Markell Morantz' article on "The Perils of Feminist History." In this article, Morantz criticizes the "presentism" of contemporary feminist critics, which leads them to look at history only insofar as it reinforces their modern ideological views about the nature of gender relationships. Such an approach results in studies which are "often too willing to distort historical evidence and lay blame, while missing a larger opportunity to explore the immense complexities which lie at the root of Victorian attitudes towards women" (239). She cites Ann Douglas Wood's article on "'The Fashionable Diseases': Women's Complaints and Their Treatment in Nineteenth-Century America," in which Wood blames a patriarchal, male-dominated medical profession as a prime culprit in the physical, as well as social, oppression of nineteenth-century women. Morantz points out that in several key instances, for example the discussion of Silas Weir Mitchell's use of the rest cure to treat female patients like Charlotte Perkins Gilman, Wood has uncritically presented only a one-sided view of historical facts. As Morantz makes clear, not all male doctors were deliberate agents of patriarchy; not all female doctors were feminist crusaders trying to save female patients from the evils of male medical science; and not all patients subjected to often-bizarre nineteenth-century medicine were helpless female victims. While Morantz may have her own biases, it is nevertheless clear that Wood—a professor of English—exhibits more ideological certainty than historical accuracy. And

like Morantz, I have found the same problem in the work of many other feminist literary critics whose textual analyses employ well-intentioned but one-sided historical information. I feel justified in taking others to task on this point only after first undertaking this project as a way of correcting my own shockingly haphazard understanding of historical events.

[6] See, for example, Chester R. Burns, "Fictional Doctors and the Evolution of Medical Ethics in the United States, 1875-1900."

Chapter One:

[1] For more information about the history of the medical profession, please see Abram, Achterberg, Berlant, Blake, Bonner, Bourdillon, Cline, Donnison, Ehrenreich and English (1973), Jex-Blake (1886), Manton, Morantz-Sanchez, Parry and Parry, Porter, Shorter, Walsh, Woodward and Richards, and Youngson.

[2] I am using the term "monopoly" here following the work of Jeffrey Lionel Berlant in his *Profession and Monopoly: A Study of Medicine in the United States and Great Britain* (1975). I take up the monopoly issue in more detail in Chapter Two.

[3] For much of the nineteenth century, alternative medicine was no worse than the allopathic kind; in fact, since irregular practitioners often eschewed the allopathic belief in heroic medicine—bleeding and purging—one was often safer in their care, however quack-like it may have seemed to regular physicians. Nevertheless, while patients in the United States may have been tolerant of a variety of medical philosophies, many of the larger United States medical schools were not, so that while women could get medical educations of varying quality, they did face a difficult struggle gaining access to the most prestigious degree programs. Envisioning themselves as the vanguards of science and

professionalism, institutions like Harvard self-consciously organized themselves around elitist principles. On the one hand, this did result in higher standards and more rigorous studies; on the other hand, it also justified them in resisting the inclusion of unconventional students—not just women, but members of all minority groups, including Jewish and African-American men. Medical schools like Michigan, Johns Hopkins, and finally Harvard did eventually admit women (Harvard held out until 1945) and other marginalized groups, but unofficial quota policies and discrimination kept their numbers low.

[4] Sophia Jex-Blake's *Medical Women: A Thesis and a History*, (1886) includes an exhaustive account by Jex-Blake of women's struggle to gain admittance to medical schools in Great Britain. One of the most valuable features of this work is her choice to include an extensive collection of press clippings—she cites numerous letters to the editor in both national and local papers, from both supporters and detractors, providing readers with a good sense of the on-going conversation about medical women in the 1870s and '80s. I have turned to Jex-Blake's sources often for contemporary commentary on the medical women's movement: many of her regional sources are now currently difficult to find; more importantly, because Jex-Blake makes her selection of clippings so deliberately a part of her invaluable historical narrative, I feel that it is appropriate to include them wherever I, and other critics, are relying on her for an understanding of the debate.

[5] Alison Bashford (*Purity and Pollution: Gender, Embodiment and Victorian Medicine*, 1998) claims that one main reason for the bubbling-over of hostility into a full riot was the particular subject of the lectures the women were trying to attend: gross

anatomy. And on the day of the sheep incident, the specific topic was scheduled to be the male genitalia: "For many men, encountering women investigating and dissecting the genitals of corpses was intolerable. It was certainly so for the participants in the Edinburgh riot . . . who, having tolerated the women for several years, saw the practical anatomy lessons which began in their third year as quite beyond the pale. Their riot was planned for the day when the perineum of the corpse was to be dissected" (115).

[6]But while such an analysis may be apparent to late-twentieth-century observers, it was certainly not articulated so explicitly in late-nineteenth-century debates about women's medical education. The taboos underlying male (and sometimes female) objections to women's presence in the dissection room may have been the source of critics' profound disgust and hostility; the unmentionable, even unconscious status of such an explanation may account for the lapses in logic and plain-speaking in the discourse of the debate—but neither the critics of women's medical education, nor the defenders of it, were able to describe the problem in the terms Bashford uses. The writers of the novels tended to skirt the issue even more. I accept Bashford's explanation, but I wonder: if observers of the day were not able to articulate the complexities of the dissection issue, were they even able to perceive them at all? If "propriety" was the most precise name late-Victorians could give to the desired relationship between dissector and cadaver, doctor and patient, then what do theories of the body and the gaze add to our understanding of their observations? Not that it is pointless to develop such theories; but perhaps these theories tell us more about ourselves than they do about the objects of historical study.

[7] This is not to mention other egregiously stereotyped ideas about women professionals; for example, male critics worried—only half jokingly—that women professionals would treat female clients badly out of romantic jealousy, wouldn't be able to keep client confidentiality, or would take advantage of their professional privileges to seduce male clients.

[8] Morantz-Sanchez (*Sympathy and Science*) also points out that many women doctors did not find it easy to combine work and family life, especially since it was often difficult to find understanding husbands (see also Rosalie Slaughter's short story, "One Short Hour," in *Daughters of Aesculapius*, Slaughter ed., 1897). Many other medical women found that the work itself was too absorbing, or too demanding of (willing) self-sacrifice, to allow for marriage. Nevertheless, women doctors still made time for close friendships (and in more than a few cases, close friendships of the "Boston marriage" variety suited pairs of professional women very well), group involvements, even motherhood through adoption. However, despite the fact that most professional women seem to have found a way to balance personal and professional fulfillment, the criterion for public acceptance of the healthfulness of study and work was still a woman's capacity for heterosexual union and motherhood.

[9] Fictional doctresses occasionally use the words "manly" or "manfully" to describe behaviour they consider admirable for its strength, decisiveness, or stiff-upper-lippishness. The women seem to be accepting the equation of terms like "manly" or "manful" with strength, which might suggest the tacit acceptance of "womanly" as equalling weakness. Perhaps the women are aware on some level that they are trespassing on male terrain; but I think it also demonstrates that the women are self-consciously

trying to prove that if medicine is a man's game, that does not mean that women cannot learn the rules and play by them. To a strong woman doctor, an action is simply either right or wrong, as determined by the nature of the medical situation; her ability to see an appropriate action as either—or both—manly or womanly is a way not of simply transgressing a gender barrier, but of dissolving it, by making both terms equate with strong, correct, useful behaviour.

[10] Vivian Lester may be man enough to know when to put pride aside, but as I note in Chapter Two, the fact that he is, in a way, cast as the damsel in distress, to be literally carried away by the heroic doctor, also makes him something of a feminized hero. (One could say the same about Waldo Yorke in *Dr. Zay*).

[11] The narrator here is deliberately copying the style of journalists of her day (and ours too, presciently) who found themselves unable to comment on a woman's professional achievements, without first detailing her aesthetic ones. There is a slightly mocking tone to this passage; the journalists, like many other people in Helen Brent's life, are too concerned about external evidence of her womanliness, rather than more important demonstrations of it, such as her strong sense of principle and compassion. The narrator's own choice of description is more subdued, although it too manages to insist on Dr. Brent's ability to be both professionally successful and feminine at the same time: "Her fine figure and beautiful face made her a walking commentary on the usual opinion that 'Mind is an enemy to beauty.' Thin, sallow, overworked school ma'ams, and big, striding women reporters, who themselves failed obviously to maintain the proper mental and physical equilibrium, always pointed to Dr. Brent as a refutation of a theory that they might be presumed to prove" (16).

[12]One woman doctor who was very much against bicycling for girls was Arabella Kenealy. In two articles on the subject of "Woman as Athlete" in the April and June 1899 issues of the *Nineteenth Century* (vol. 45, pages 636-645 and 915-929), Kenealy sets forth her argument that while exercise and study are fine for young women, either physical or mental activity in excess is guaranteed to deprive a young girl of her supposedly natural charm and delicacy and turn her into what Kenealy calls a neuter. Kenealy believed that

> in either sex there is an underlying latent strain of the opposite sex—this in order to create a bond of sympathy whereby each may be intelligible to the other. The stress of over-education, over-athletics, or the exhaustion consequent on disease, may so impoverish and incapacitate that the specialised powers of an individual of either sex may lose their natural supremacy. The strain of the other sex, no longer kept in its normal state of latency, receives an artificial stimuli [sic], develops, flourishes, and may finally dominate and spoil that which might have been a complex perfect organism. (916)

Her evidence for these claims, which "cannot be doubted" apparently comes not from empirical observations, but from some rather questionable assumptions about race, class and evolution: to her, a life of physical activity equals racial or class inferiority, a notion she bases on the ill health of the labouring classes and the incomprehensible (to her) gender relations of aboriginal cultures. As J. Ormistan Chant points out in a "Reply to Dr. Arabella Kenealy" (ibid., 745-754), Kenealy is simply spouting nonsense (Chant puts it more diplomatically of course). Nevertheless, Kenealy's views are fascinating for what they reveal about the very uneven state of medical-scientific thought of the day: the scientific method was evolving, but was by no means universally adopted overnight. More importantly for this investigation, Kenealy's example makes clear the fact that late nineteenth-century medical women were not at all a homogeneous group. Their varied attitudes towards medicine, morality (including issues of race, class and the growing eugenics movement), and gender reflect women doctors' divided, sometimes conflicting, loyalties to their sex, their profession, and their individual value systems.

[13] See Sally Mitchell's *The New Girl: Girls' Culture in England, 1880-1915* (1995), and Bruce Haley's *The Healthy Body and Victorian Culture* (1978).

[14] It is interesting to note the contrast between fictional doctors of the late nineteenth and late twentieth centuries, especially if we compare the early medical women of the novel to modern medical women as portrayed on numerous hospital dramas. If television is based at all on reality (and a program like *ER* certainly promotes itself as doing so), women doctors today must check their femininity at the door (in behaviour, though not necessarily appearance). Especially in high-pressure, fast-paced environments like trauma or surgery, the preferred attitude is tough, aggressive and unemotional—an attitude that is still stereotypically characterized as masculine. The would-be doctor—male or female—who cannot conform to this model of behaviour does not last long. On such programs, there are frequently episodes where the women doctors (and sometimes, the more sensitive men) are faced with the decision to either go hard, or go home—or go to a more sedate, possibly more feminized medical environment. It seems that, in the fictional realm at least, the medical field is still the scene of conflict between gendered behaviours. And if early medical women sought to deal with this conflict by preserving womanliness and femininity as a complement to (and

acknowledgement of) the dominant masculine mode of behaviour, it also seems that, in some areas of medicine at least, that strategy has not stood the test of time. In the higher-pressure (and, often, higher-status) areas of medicine, the stereotypically masculine pattern continues to dominate, and doctors of both sexes seem to accept that as the status quo.

Thus much for modern fictions about women doctors: for discussions of the gender barriers still facing real-life medical women, see Rosemary Pringle's *Sex and Medicine: Gender, Power and Authority in the Medical Profession* (1998); Elianne Riska and Katarina Wegar's *Gender, Work and the Medical Division of Labour* (1993); and Penina Migdal Glazer and Miriam Slater's *Unequal Colleagues: The Entrance of Women into the Professions, 1890-1940* (1987).

[15] Sophia Jex-Blake, by contrast, felt that, aside from *Mona Maclean*, the other doctress novels were not shoppy—or political—enough. In her review of the novels as a group (*The Nineteenth Century*, 33 (Feb. 1893): 261-272), Jex-Blake expresses her disappointment that many of the novelists have written on a topic of which they have little first-hand knowledge:

> We certainly have no right to ask—and I for one am very far from asking—that all sketches of medical women should be drawn by friendly hands; but what I do think the public have a right to require is that it should not be necessary to write under a portrait, 'This is a Lion;'—that such portraits should be in some sense taken from life; and that they should not—like the famous camel of the German scientist—be evolved over a study fire, from the depths of the author's inner consciousness. (263-62)

Jex-Blake critiques most of the novels for not engaging directly enough with the issues behind the medical women's movement; she is also irritated by the number of novels written by medical lay-people. Her favourite of the "half-dozen romances of the last twenty years that have dealt more or less seriously with the *genus* medical woman" was written by a woman doctor, and a close friend, Margaret Todd.

Chapter Two:

[1] The British Medical Association's constitution did not specifically exclude women in its wording, but the rules against foreign degrees, when no domestic universities were open to women, served as a sufficient barrier for the first few years of the women's campaign. Once women established their own schools, government passed the Enabling Act of 1876, and women were graduating with British MB's and MD's, the wording of the constitution did become the subject of much debate.

[2] The following sources all offer thorough analyses of effects that male-dominated professional monopolies have had—and continue to have—on women: Abram, Ruth J. ed., *"Send Us A Lady Physician": Women Doctors in America, 1835-1920*, 1985; Catriona Blake, *The Charge of the Parasols: Women's Entry to the Medical Profession*, 1990; Penina Migdal Glazer and Miriam Slater, *Unequal Colleagues: The Entrance of Women into the Professions, 1890-1940*; 1987; Regina Markell Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine*, 1985; Rosemary Pringle, *Sex and Medicine: Gender, Power and Authority in the Medical Profession*, 1998; Elianne Riska and Katarina Wegar, eds., *Gender, Work and Medicine: Women and the Medical Division of Labour*, 1993; Mary Roth Walsh, *"Doctors Wanted: No Women Need Apply": Sexual Barriers in the Medical Profession, 1835-1975*, 1977.

[3]"We cannot know for sure whether or not this generation of women [in the late nineteenth century] was sicker than their grandmothers. What is certain, however, is that they *thought* they were" (Morantz, "Making Women Modern," *Women and Health in America: Historical Readings*, Judith Walzer Leavitt, ed., 1984.) Why late nineteenth-century women (and many of their physicians) believed that they were, as a group, in poor health, can be attributed to many causes: poor hygiene, poor diet, restrictive dress, poor living conditions, lack of exercise, and—some would argue—an unconscious tendency on the part of doctors (especially men) to medicalize women's physical and emotional complaints.

[4]In her study, Morantz-Sanchez does point out that the hospitals were not identical; they had somewhat different admission and treatment policies, and attracted patients from slightly different socio-economic groups. For example, patients at the female-run New England Hospital tended to be better able to pay for hospital services than patients at the male-run Boston Lying-in. Morantz-Sanchez points out that, "[i]ronically, women physicians attracted a somewhat different type of patient, with somewhat different medical and social problems, and this in turn affected the type of medicine women doctors practiced" (227).

[5] In a television program like *ER*, for example, the medical details are presented as being just as interesting, if not more so, than the relationships of the program's main characters. Taken to a logical extreme, the result is other programs like *Trauma: Life in the ER*, where viewers can tune in to see real, documentary footage of hospital life, without being bothered with plots and characters at all.

[6]For examples, see Edward Burdoe's *St. Bernard's: The Romance of a Medical School* (1887) or Sarah Grand's *The Beth Book* (1894).

[7]See Judith R.Walkowitz's *City of Dreadful Delight: Narratives of Sexual Danger in Late-Victorian London*, 1992.

[8] I find that Howells seems to have a predominantly disparaging view of women, at least in *Dr. Breen's Practice*; not only is his medical woman cast in an unflattering light, but the many other women in the novel are shown to be even greater victims to the pull of convention. In fact, Dr. Breen discovers that women are just as likely, if not more so, to regard the emancipated female with suspicion and distrust; or to pronounce themselves all for women's rights, only to be totally besotted by the more old-fashioned type of man's man, represented by Dr. Mulbridge. I cannot blame Howells for being uniquely sexist in this regard though, since other authors of the doctress novels, including Anne Elliot and Annie Nathan Meyer, also identify women's blind adherence to tradition and stereotypes as being one of the larger social obstacles to the progress of women's professionalization. Women, as well as men, regarded women doctors, and their unconventional personal and career choices, with suspicion.

[9] It is important to note that both Elizabeth Stuart Phelps's *Doctor Zay* (1882), and Sarah Orne Jewett's *A Country Doctor* (1884) were written at least partially as corrective responses to Howells' portrayal of Grace Breen. As Jean Carwile Masteller describes in detail in her article, "The Women Doctors of Howells, Phelps, and Jewett: The Conflict of Marriage and Career" (Gwen Nagel, ed. *Critical Essays on Sarah Orne Jewett,* 1984), Howells knew that his serialization of *Dr. Breen's Practice* in *The Atlantic Monthly* would be followed by Phelps' *Doctor Zay*, since the two authors were in correspondence (Ann Jurecic also discusses the relationship between Phelps, Jewett , and Howells in her dissertation, *The 'Genus Medical Woman': Representations of Female Doctors and Nurses in American Fiction from the Civil War into the Twentieth Century* [1994]). Moreover, once Howells' novel had run its course, Phelps wrote to him to say, "I don't feel that Dr. Breen is a fair example of professional women; indeed, I know she is not for I know the class thoroughly from long personal observation under unusual opportunities" (Masteller, 135).

[10] This outcome is foreshadowed quite deliberately in Vol. I, when Fullagher characterizes Edith as "Penthesilia." Since Fane's sister Sibyl does not get the classical reference, Fullagher has to tell her—and the readers—about the basis of his comparison. Penthesilia was an Amazon queen who sided with Troy against the Greek forces. In the battle, she ended up in single combat with Achilles, who did not realize that his worthy opponent was a woman—until he slew her. Then, only as she lay dying, did he see her face, and promptly fell in love with her, when it was too late (I, 228-29). Fane is similarly smitten by his "Amazonian" competitor; their romance, however, does not seem to be similarly doomed.

The comparison with Penthesilia works very well for this novel; but it was probably more common for nineteenth-century writers and readers to draw a parallel between the medical woman and the mythical Atalanta (see Masteller, 140 and Jurecic, 148-50). Atalanta was another instance of the formidable woman from classical legend; she was a mighty huntress and devotée of Artemis who resisted capture by would-be suitors. She claimed that she would only marry the man who could match her own strength, by beating her in a foot-race. No man could, until Hippomones—with the sympathetic help of Athena—employed the fabled trick of the three golden apples. As he ran the race with Atalanta, he cast the apples aside one by one; she, unable to resist the temptation, stooped to pick them up, and so fell behind and lost the race. Critics of women's educational and economic competition with men were fond of this image, seeing in it woman's inevitable weakness against the greater intellectual strengths of her male opponent. But some supporters of women's rights also seemed to find the image compelling, perhaps interpreting Atalanta's defeat as a compromise that brings happiness to both her and her suitor, and maintains a natural order in sexual relations—Atalanta is still mighty, but she does not need to be alone, once she has encountered a worthy match. For example, the editors of *Atalanta*, a magazine for girls published 1887-96, chose to feature the image of Atalanta stooping for the apples on the frontispiece of each annual collection; the ideas of female strength and self-sufficiency (in the shape of career advice, for instance) are then combined with traditional notions about female nature and the natural roles of wife- and motherhood throughout the magazine:

. . . Oh, girls! 'tis English as 'tis Greek!
Life is that race! Train so the soul
That, clad with health and strength, it seek
A swifter still, who touches goal
First; or—for lack of breath outdone—
Dies gladly, so such race was run!

Yet scorn not, if, before your feet,
The golden fruit of life shall roll,
Truth, duty, loving service sweet,
To stoop to grasp them! so, the soul
Runs slower in the race, by these;
But wins them—and Hippomenes!
(Edwin Arnold, *Atalanta*, Vol. I, October 1887)

[11] It is important to point out, however, that almost none of the novels which I have studied attempt to perform a detailed portrayal of what married life might be like for the doctress and her enlightened husband. Partly, this inability, or unwillingness, to read beyond the ending (to cite Rachel Blau DuPlessis) may be simply due to the constraints of the romance form; once again, the form takes precedence over the logical or realistic rendering of the content. Or perhaps the authors—especially the majority who support women's careers—do not want to complicate their propagandistic efforts by dwelling on the inevitable difficulties in store for the emancipated couple. The one novel which does feature a woman doctor who is already married is *Mrs. Keith Hamilton, MB* (Annie Swan, 1897), the sequel to *Elizabeth Glenn, MB* (1895)—but both novels are, interestingly, *not* romances. That is, they are really just a series of anecdotes and smaller narratives related by Elizabeth Glenn Hamilton to the narrator, about her cases. Some of these episodes do have some romantic content, but the woman doctor is involved only as an observer and advisor; her own romance with the elusive Keith Hamilton takes place at a far remove, and is more reported than narrated. So, in Mrs. Keith Hamilton, the novel

does not deal much at all with any conflicts faced by the woman doctor and her husband—although she does find herself practising medicine less and less as she becomes more preoccupied with domestic concerns.

Chapter Three:

[1] Of course, this means trained medical care as judged by western standards. While medical missionaries seemed to have found much to respect in Eastern cultures, they nevertheless regarded much "native" medicine with amusement at best, contempt at worst (See Harriet Dufferin, "The Women of India," *The Nineteenth Century*, March 1891).

[2] In 1870, Queen Victoria wrote of her profound disgust with the women's rights movement, and such issues as the suffrage, and the entrance of women into the professions. However, by the mid 1880s, Victoria was apparently willing to relent towards medical women—at least those willing to work in India. There is an oft-quoted story from nineteenth-century supporters of women medical missionaries describing how a western medical woman, Miss Beilby, saved the life of the Maharani of Punna. The Maharani was grateful, and wished that all Indian women could benefit from women's medical attention. She implored Miss Beilby to deliver a request to Victoria; the Queen was so impressed by the great need of Indian women that she immediately asked Countess Dufferin to take action (See Dufferin, "The Women of India," and Williamson, The Healing of Nations).

[3] Real-life medical women were often strongly against such practices as abortion, and were horrified when abortion practitioners advertised themselves as doctors:

> The gross perversion and destruction of motherhood by the abortionist filled me with indignation, and awakened active antagonism. That the

> honourable term "female physician" should be exclusively applied to those women who carried on this shocking trade seemed to me a horror. It was an utter degradation of what might and should become a noble position for women. (Blackwell, *Pioneer Work for Women*, 24)

However, as some historians suggest, the medical profession in general was more accepting of abortion than birth control, since the latter threatened to lead the way towards sexual permissiveness. For more on this issue, see *Sympathy and Science* (Morantz-Sanchez, 1985), and *Women and Health in America* (Leavitt, ed. 1984).

[4] As Judith Walkowitz points out in *Prostitution and Victorian Society: Women, Class and the State* (1980), most nineteenth-century reformers had a poor understanding of the causes and consequences of prostitution. Most prostitutes were not hardened, amoral criminals, but simply lower-class women forced to turn to the sex trade as a temporary financial expedient. Prostitution for most was less a life-long career, and more of an interlude, before the woman went on to find better work, and usually, "respectable" marriage. While incarcerating young women in lock hospitals may have satisfied some reformers, that was about all such institutions did. Otherwise, Walkowitz claims, the lock hospitals were a failure—they did not contain disease or rehabilitate their unwilling patients, and only "imposed a social discipline and therapeutic regime [of personal cleanliness] on female venereal patients that incorporated the class and sex prejudices of the dominant Victorian culture" (65).

[5] Annie Nathan Meyer had little to say on the subject of women doctors in her autobiography, *It's Been Fun* (1951). All she says about *Helen Brent, M.D.* is that reviews assumed the author "to be a sour old maid" (218). There was one exception, from

the one reviewer who knew the true identity of the then-anonymous author: "I remember with what glee Jeanette Gilder announced that it was written by a young and happily married woman." Meyer was not a doctor herself; the daughter of a wealthy Jewish family in New York, she was able to make a career out of being a writer, a socialite, and, as her reviewer friend noted, a wife happily married to a successful physician. Meyer prided herself on being ahead of her time; *Helen Brent* "handled with great frankness the theme of social evil" long before other works did (she does not mention Ibsen); and she considered herself quite progressive in capturing the black experience in her plays (with the approval, she says, of many black people). Meyer was also, interestingly, an "Anti": she was against the suffrage because "I was disgusted by the fantastic claims that were made as to the results that were certain to happen. That, and also a distinct flavor of sex hatred (which was always denied, but which nevertheless I always encountered), made the suffragists unsympathetic to me" (203).

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Appendix 1:
Plot Summaries of the Doctress Novels Discussed in This Dissertation

The title of **Annie Thomas'** ***New Grooves*** **(1871)** refers to the vow of the novel's heroine to seek out "new grooves" for the course of her life; after her father dies, Ethel Borrodaille resolves to look after both herself and her mother, achieving independence through the pursuit of some modern career. But before she can decide on a career plan, Ethel finds herself accepting a proposal of marriage from Mr. Weston—one of his principal charms being that he has bought the family home after Mr. Borrodaille's debts forced his widow and daughter to sell. Ethel has not gone very far at all in her new grooves before she ends ups going over a much older one—where the heroine marries well and maintains both her own status and that of her family. But the marriage is a happy one—until Ethel, weakened by too much luxury and dissipation, develops complications during pregnancy. She suffers terribly, but worse than the physical pain is the pain she experiences upon being subjected to the care of a male physician. The affront to her modesty is almost more than she can bear; and when she has recovered she vows to spare other women the same torment by becoming a doctor herself. And this is nearly all we hear of the matter of her medical work. We hear little of the struggle to gain access to a medical education; we hear more of her to struggle to win her husband's approval and support. The problem is not that Mr. Weston is against his wife's choice of career; but rather, that he is being manipulated by his cousin Fanny, who is seeking to break up the marriage so that she can have Weston for herself. In the end, Ethel is able to reveal Fanny's true colours to her husband, their marriage is saved, and Ethel is free to continue with her medical work.

In **Charles Reade's** ***A Woman Hater*** **(1877)**, Dr. Rhoda Gale is made to play a central role in the plot, but she functions in the narrative more as a plot device, and an excuse for the narrator to pull out a few of his favourite hobby-horses, rather than as a central character in her own right. Rhoda does not even appear in the story until it is well underway. The first several chapters of the story introduce the Woman Hater, Harrington

Vizard—so called because he invariably falls in love with one woman after another, only to be jilted, and temporarily embittered. He is joined in his life of upper-class leisure by his sister Zoe, her cousin Fanny Dover, and Zoe's suitor, Edward Severne. The plot is a complicated one of romance and intrigue: Zoe loves Severne but Severne is revealed to the readers to be a lying con artist with a gambling problem; he also turns out to be the fugitive husband of Ina Klosking, a famed European chanteuse. Her search for Severne brings her into contact with Vizard and his sister—and Vizard falls head over heels for Ina. The story is only resolved when Severne's sinister designs to seduce Zoe and bilk her of her fortune are revealed. She is set free to marry Vizard's reform-minded neighbour, Lord Uxmoor. A repentant Severne follows Ina about on her singing tour, until he is killed in a freak accident, which then allows Ina to marry Vizard. And Fanny settles down and marries the local minister. It may be difficult to see where Dr. Rhoda Gale fits in to such a story, and, indeed, her introduction is certainly awkward enough. In the middle of the romance narrative, Vizard happens to be walking through London alone when he encounters a fainting Rhoda—he comes to her aid and learns that she is sick with hunger. He insists on taking her to an inn to eat, and as she recovers, she tells him her story. The next sixty-odd pages are a complete detour from the main action of the novel as Rhoda relates her life story to date. A precocious child, educated by liberal but intellectually rigorous parents, she grew up with an interest, and a well-fostered aptitude for science and medicine. Her medical education brought her into the midst of the struggle for women's admission to British medical schools, headed by Sophia Jex-Blake (that heroic woman is only praised, but not named). When the women's progress is frustrated in Edinburgh, Rhoda finishes her studies in Europe—but no sooner has she successfully graduated than she learns that her father dies. Her mother means to join Rhoda in England, and bring the family fortune with her, but is delayed by a dispute over the will—which accounts for Rhoda's own financial crisis and starvation. Vizard is so impressed by the tale of womanly fortitude, determination, and talent versus coarse, unmanly trades unionism that he feels he must help

Rhoda beyond giving her one meal—and so introduces her into his household as the new doctor for his tenants and villages in Barfordshire. Within days of taking up her new post, Rhoda is ready to report to Vizard about the appalling state of public health and hygiene amongst the poor. She goes from being a spokesperson for the cause of women doctors, to being a spokesperson for progressive theories about the safety of the water, and the health of the race, and provides Reade with several opportunities for criticizing the ignorant poor, and their well-intentioned but misguided superiors. All of which is by the way of the main action of the romance: there, Rhoda plays a functional role, taking care of, and thus demystifying, the mysterious Ina Klosking, and revealing Severne's true identity as Ina's truant husband (Rhoda had attended Ina and Severne during her medical school days in Europe, and so recognized him later). At the end of the novel, when all the romantic loose ends have been tied up, Rhoda is left as the lone single woman of the group—but she is content that way, making a far better chum for Vizard than a wife for anyone else, while she dedicates herself to practising medicine and public health reforms.

In **1881, Major General G.G. Alexander** made a woman doctor the central character of his ***Doctor Victoria: A Picture from the Period***. Like Reade's *A Woman Hater*, *Doctor Victoria* involves a question of identity—but here, the mystery surrounding Victoria's illegitimate birth is used to set up a framework of disparate characters whose different class backgrounds and predicaments allow the narrator to make pronouncements on a variety of social issues. Victoria's connection to the lower classes, through the little blind Madge, who later turns out to be her cousin, gives the narrator justification to peer into the seamy underside of London life, and to make Dickensian portraits of ignorance, sin, and moral and urban decay. The suffering and dissolution of the lower classes is shown to be exacerbated by the callousness of upper middle class capitalism, especially of the kind practised by brewers and other liquor manufacturers like Mr. York, the man who is ultimately revealed as Victoria's real father. Victoria's illegitimacy leaves her bound to decline the marriage proposal of Sir Francis: unable to marry within her own class because of the stain on her lineage, she channels her noble female nature into medicine, first as a nurse, and then as a doctor. The medical aspect of her life remains in the background for much of the novel's three volumes, except insofar as it seems to bring her to heights of maturity and wisdom. She becomes the authority figure and advisor to all who know her, including her closest female friends (who are all contrasted with Victoria, in all their faults and feminine weaknesses). In the one instance where we actually see Doctor Victoria in action, it is as she single-handedly brings about a miraculous restoration of Madge's eyesight. By giving the girl literal light, she also offers her the light of spiritual and class redemption, reclaiming her cousin as part of her legitimate family, alongside her half sisters, Mr. Yorke's other daughters.

In ***Dr. Breen's Practice*** **(William Dean Howells, 1881)**, Dr. Grace Breen is right out of medical school, after studying to be a homeopath—a career she'd chosen after a bad love affair. Her first case is to look after a former school acquaintance—but Louise Maynard, despite wanting a woman doctor in particular, fails to be impressed with Grace's medical authority, and exacerbates her condition by going out for a sail, and catching a bad chill. When her chill turns into a more serious fever, she dismisses Grance, demanding to see a "real" doctor—a man, and an allopath. Grace is forced by professional responsibility—and a lack of faith in her own powers—to call in Dr. Mulbridge to take over the case, while she demotes herself to the role of nurse. Throughout the care of Mrs. Maynard, Grace grows closer to both Dr. Mulbridge and the handsome Mr. Libby, a family friend of the Maynards who is staying at the same hotel. Disenchanted with her medical career, and longing, by her own admission, to just be a girl, she is tempted by marriage proposals from both men. But despite Mulbridge's conviction that Grace longs to be mastered by a gruff and domineering man like himself, who could set her free from her girlish notions about being a doctor, she ends up by choosing Libby, who seems to have more respect for her. In fact, while Grace seems determined to give up her medical career altogether, Libby encourages her in her own "Puritan" impulses to do good for others, and after an entertaining honeymoon, she ends up by taking over the care of Libby's factory workers, to the apparent satisfaction of both Dr. Grace and her husband. In the end, while the novel does not paint a convincing portrait of woman's capacity for medical authority, it does leave Grace practising medicine.

Elizabeth Stuart Phelps' *Dr. Zay* (1882) is less ambivalent in its portrayal of the medical woman. From the very beginning, Dr. Zaidee Atalanta Lloyd is shown to be the very model of the competent, authoritative woman doctor, who is nevertheless able to maintain all her womanliness, and an appropriately feminine interest in stylish clothes and decor. The story is told largely from the perspective of Waldo Yorke, a wealthy young man, nominally a lawyer, but more seriously a dilettante, who ventures into the wilds of Maine to follow up on an inheritance. He promptly has a serious buggy accident—and when he comes to, finds himself under the competent homeopathic care of Dr. Zay. His lengthy recovery allows the story to invert the stereotypical gender roles: Yorke, in his weakened state, is made to play the role of passive and dependent patient more traditionally reserved for women; Dr. Zay is cast in the role of the country doctor, with power over both Yorke's physical condition, and his emotional state. He soon falls in love with her, but when he eventually professes his feelings, Dr. Zay turns him down, out of a professional obligation not to take advantage of her patients—not to mention a concern for what such an action would do for the reputation of women professionals everywhere. Yorke is driven away by her rejection, but becomes determined to win her love; he eventually returns to try again, after regaining his masculine power through a recovery of health, career, and self-respect. He proposes again, offering to move his own law practice to Maine, to allow Dr. Zay to continue caring for the poor local women, who have no one else but her to turn to. She still resists, but, now that he has regained his masculinity, he is no longer a patient at her mercy—as an equal, he exerts his own influence on her, and in the end persuades her to accept him.

Anne Elliot's *Dr. Edith Romney* (1883) is a three-volume novel detailing the professional and romantic trials of the eponymous heroine. When the novel begins, Edith has established a thriving practice in the manufacturing town of Wanningster. She offered the people youth, progressive ideas, and, by virtue of her sex, a hint of scandal, that appealed to the fashion-conscious trendsetters of local society. As a result, the practices of other doctors have suffered, most notably that of Dr. Fullagher, who has been forced into retirement by the lack of business. Fullagher blames Edith—whom he has so far not met—for stealing his patients. To get even, he encourages the handsome young Dr. Fane to settle in Wanningster, and to take on Edith professionally. Dr. Fane, as much a self-avowed woman-hater as Fullagher, likes the idea—until he gradually begins to learn that Edith is in fact no fad, but a highly competent physician. Fane begins to feel remorse for his actions, especially once he finally meets Edith and realizes that she is no virago, but a beautiful woman with whom he thinks he can see a future—but his regrets come too late. His tactics—flattering both the older women and their husbands, and holding out hope as a good match for their daughters—are successful, and Edith is gradually dropped by all her most well-to-do patients. Worn down by the personal and financial strain, Edith's health suffers, and eventually she falls dangerously ill. Fullagher is called in to oversee her care and recovery—his attendance, and that of Fane, who now realizes that he is in love with a woman he has tried to destroy, teach them both important lessons about the rights of women. Her illness is also instructive to Edith, and she regains both her health, and a renewed commitment to her career for both personal and political reasons. She has been defeated in Wanningster, but it is her one-time rival, Fullagher, who finds her a new post in a new town. As she is about to leave, Fane proposes—he is still skeptical about her career, but he is willing to try to be open-minded in return for her love. The novel closes somewhat inconclusively—Edith seems to physically accept Fane's offer, but does not speak her acceptance, or, if she has any, her doubts.

Sarah Orne Jewett's *A Country Doctor* (1884) is as much a meditation on nature, spirituality, and the purity of country life, as it is a defense of the medical woman. Anna—Nan—Prince is orphaned almost immediately after birth. Her mother had left her small New England hometown to marry Nan's father, and to pursue her ambitions and dreams for a larger life. But the Princes were beaten down by life and estranged from their families. Now, Mr. Prince has died, and Mrs. Prince has returned to her mother, physically sick, and, in a suicidal state of mind, showing signs of the family's hereditary mental weakness. Mrs. Prince leaves Nan in the care of her mother, and by extension, her like-minded rural neighbours, who all share an organic and reverent connection to their native soil. When Nan's grandmother dies, Dr. Leslie, the prototypical country doctor, becomes her guardian. His philosophy of child rearing is to let God and nature form the mind—so that while Nan's eventual decision to pursue medicine strikes him as unconventional, he supports it wholeheartedly; sex, he believes, is no barrier to God-given ability, and a God-fearing desire to serve. Nan's medical school days are largely left a narrative blank—Nan does well, faces down all opposition, and promises to be a deserving successor to Dr. Leslie. However, her studies are stressful, and during a much-needed vacation, she decides to try to get reacquainted with her father's family. She finds her aunt Prince to be formal and conventional, but more than willing to welcome Nan back into the family. Nan quickly endears herself, and although she is disapproving of Nan's choice of career, Miss Prince is ready to make Nan her beneficiary. Miss Prince's greatest hope is that Nan will also marry the young man her aunt has taken on as a protégé, George Gerry. Nan finds herself very attracted to George, and to his enjoyment of leisure and fun. Ultimately, however, Nan realizes that all that George can be to her is a temptation from her true calling. Nan declines George's proposal, and returns to medical school. She graduates with honours, and has her choice of prestigious positions—but she returns to her small town, to be groomed as Dr. Leslie's successor, and to fulfill her spiritual devotion to serve and help the simple country people.

Henry Curwen's *Dr. Hermione* (1890) is in some ways the story of two medical women. Edith Falconer has been left nearly penniless by her late, improvident, father—but she has been taken up as a protégée by Dr. Hermione Hartley. Dr. Hermione is funding Edith's studies at Girton, as preparation for a medical career. Dr. Hermione herself studied, with honours, in Paris, and at one time worked among the London poor alongside Mr. Vaughan, a socialist and reformer. However, Hermione found the work too demanding, and retreated to her family estate, where she cares for the poor locals who also exploit her for generous tips. The story begins with the arrival from India of Tom Thornton, Edith's cousin, and his friend Major Dundas. The men bring some fun and frivolity to the women's nunlike existence, and the four start to pair up. They are often chaperoned by Dr. Jones, who sides with Thornton in arguing against medicine as a career. Dr. Jones' talk of women who have found their greatest satisfaction in being wives and mothers strikes a chord in Hermione, who begins to doubt her calling. The men are then called back to duty, to be sent into action in Africa. Hermione is depressed by their absence, so Dr. Jones invites Mr. Vaughan to visit, in the hopes that the latter will be able to rekindle his relationship with Hermione, to offer her a wholesome married life, and the prospect of reform work in London. Much to Dr. Jones' surprise, though, Mr. Vaughan agrees with the women that travel and experience is what they need. In a somewhat implausible turn of events, when we next see the whole group, they are unpacking a Fortnum and Mason's picnic at the army camp where Thornton and Dundas are stationed. Once the battle has begun, Hermione volunteers her medical skills—but when Thornton turns up as a patient, she has an hysterical collapse. When the two are out of danger, all Hermione can do is be his nurse, not his physician. Thornton proposes, and Hermione accepts, pleased to be a conventional woman, who can fight for her husband's causes rather than her own. Dr. Jones, who earlier extolled the virtues of marital and maternal bliss, is now surprised and somewhat disappointed that Hermione was so easily defeated. Edith also happily gets engaged, to Dundas, and decides to give up Girton, and her further career plans, for married life. Hermione is to go to India with Thornton, but whether to help him as just a wife, or also as a zenana medical missionary, is unclear.

Helen Brent, M.D.: A Social Study **(Annie Nathan Meyer, 1892)** begins with a description of Helen's successes to date. After an impressive career as a medical student in Europe, Helen has begun practising among women patients in New York. She has won the full confidence of the wealthy Mrs. Root, who appoints Helen as the head of the new Root Memorial Hospital and College for Women. But Helen's new position is not seen as a positive victory for feminists—many women are disappointed that Helen has chosen mostly men to make up her new faculty. Helen is an unsentimental feminist, and puts her concerns for the good of humanity ahead of specific causes, if such a choice seems the most beneficial. Harold Skidmore, an up-and-coming political lawyer, is baffled by Helen's ideas, and disapproves of her career choices; in his opinion, women ought only to look after their husbands, children, and homes. And yet, he still loves Helen, and tries to propose to her, thinking that she can put love ahead of principles. Helen is tempted, but refuses, knowing that she could never be happy with Skidmore—nor could he be happy with her. Eventually, Skidmore finds a conventional woman who suits him, and who is, at first, content to be his wife and a lady of leisure. However, as Helen had foreseen, Skidmore becomes increasingly involved in politics and is never home—leaving his wife, Louise, feeling bored and neglected. The rascal Verplank—a ladies' man who has broken the hearts, and health, of many formerly pure young society women—presents himself for an affair. Louise becomes pregnant and ill thanks to Verplank, but even the threat of losing his wife is not enough to persuade Skidmore to spend less time at the office and more time at home. Through Helen's care, Louise recovers her health, only to run off with Verplank and leave Skidmore devastated. Finally, Skidmore has learned his lesson, that only an equal is suitable for a wife. He asks Helen if there is a chance for them, on her terms (which are still always the terms best for all)—her answer is left for the readers to supply.

Arabella Kenealy's ***Dr. Janet of Harley Street*** **(1893)** is primarily the story of Phyllis Eve. Phyllis has agreed to marry the wealthy Marquis de Richeville—but one day he is overcome by his lust for her innocent beauty, and he attempts to kiss her. She is so instinctively disgusted that she flees, and begs her mother to call off the wedding. Her mother refuses, and convinces Phyllis to go through with the ceremony. But although she is now married, Phyllis cannot endure being with the Marquis, and decides to run away to London. She leaves a note for de Richeville, suggesting divorce, not realizing how difficult it will be to get this remedy. After roaming London in a fruitless search for work and shelter, she finally comes to the Minerva Hospital for Women. There, she is turned down as a nurse, and is so dispirited, she faints in the stairwell. She is brought round by the medical attentions of the imposing Dr. Janet Doyle, the hospital's senior physician, and dean of the women's medical school. Dr. Janet takes Phyllis home to look after her, and once Phyllis is recovered, Dr. Janet offers to help her become a doctor. Phyllis, buoyed by Dr. Janet's encouragement, accepts, and begins the difficult process of starting medical studies from scratch. Dr. Janet sends for Phyllis' mother, and both older women agree that Phyllis ought to go back to her husband—until Phyllis comes close to committing suicide. Dr. Janet gives in, and once Phyllis' mother dies, Phyllis is free, for the time being. But then Dr. Paul Liveing, a friend and colleague of Dr. Janet, begins to fall in love with Phyllis. Dr. Janet wants to protect her from all men, to keep her as her own protégée; and she knows, what Liveing does not, that Phyllis cannot marry since she has a husband already. Phyllis falls in love with Liveing in spite of herself, but for the moment, does not give in to his arguments that the grind of medicine is better left to men. In the midst of their growing relationship, de Richeville appears on the scene and tries repeatedly to get Phyllis back, first by temptation, then by force, and finally by lawsuit. Phyllis still refuses to go, and only the threat of scandal that would come with having to physically drag his reluctant wife home keeps de Richeville at bay. Then comes apparent good news: de Richeville is reportedly dead. Phyllis completes her degree and marries Liveing, putting her career on hold to be a wife and housekeeper for him. All seems well—until they discover the awful truth, that de Richeville has faked his death in order to trap Phyllis. Now she looks like a bigamist: if de Richevelle divorces her she would be free, but branded by scandal; if he does not divorce her, the scandal is even worse. Worn down by the strain of this harassment, and the demands of a difficult pregnancy, Phyllis becomes deathly ill , and loses the baby. At this point, it is Dr. Janet who intervenes. She confronts de Richeville and explains one of her theories of evolution, that "a life which is worthless to itself and harmful to others may, in some way, atone by sacrifice" (319); de Richeville is unmoved. Later, though, in a freak accident he sustains a concussion; when this is complicated by delirium tremens (he is a thoroughly debauched scoundrel) and a guilty conscience, he is driven to shoot himself. Dr. Janet feels responsible, but is not sorry for the outcome.

Neither ***Elizabeth Glenn, M.B.: The Experiences of a Lady Doctor***, nor ***Mrs. Keith Hamilton, M.B.: More Experiences of Elizabeth Glenn*** **(Annie S. Swan, both 1895)** are novels with linear plots; they are both better characterized as collections of anecdotes or short stories. *Elizabeth Glenn* is Elizabeth's account, to her friend the narrator, of her most memorable cases in the first years of her practice. After studying in Dublin, Paris, and Vienna, Elizabeth has set up practice in Bloomsbury. Her cases involve as much psychological intervention as medical treatment, as she saves her patients from blackmail, suicide, and marital disintegration. Elizabeth specializes in helping wronged or misunderstood young wives, and in teaching respect and humility to insensitive husbands. Her patients are not the exclusive subjects of her anecdotes, however; the narrator is able to draw Elizabeth out enough to get the story behind "Her Own Romance." As Elizabeth reveals, Keith Hamilton was her childhood sweetheart, until he found out about Elizabeth's plan to become a doctor and a zenana missionary. He cannot reconcile her career ambitions with his need for a wife who can serve as a suitable mistress to a respectable estate. He leaves Elizabeth free to go to medical school—with no prospects of marriage when she is done. But after years of separation, the two meet again. This time, Elizabeth has been called in to care for an old friend, Effie Lawrence—who is also, coincidentally, engaged to marry Hamilton. Elizabeth is mortified, but she is also genuinely concerned for her friend, and prays for her recovery. Effie knows that her case is hopeless, and thanks Elizabeth for doing her best; she then asks Elizabeth to look after Keith, with her blessing. When Effie dies, she leaves behind a fiancé who is depressed by his loss, and impressed with Elizabeth's combination of womanly charm and intellectual achievement. After a suitable period of mourning, he proposes. In *Mrs. Keith Hamilton*, the narrator continues to report on Elizabeth's doings. Now that she is married her medical career has become more of a hobby. Elizabeth helps her husband establish a county hospital where she will be chief resident—and yet she does not spend much time there. She has plans to establish her own hospital for women, but is talked out of it, and opts to run a settlement house for young women instead. These various philanthropic projects again serve as means for Elizabeth to practise her skills in social work as much as medicine. Again, she intervenes to save people from hurting themselves or others in bad marriages (often ones involving inequalities of class). Finally, Elizabeth's contribution to her friend's book comes to an end, when she becomes pre-occupied by the care of a new baby, and her husband's estate, including the poor tenants, who continue to rely on her for both medical care and charity.

In **George Knight's *The Winds of March* (1897)**, Babs Cameron is an unconventional young woman who shocks the Reverend Anthony Magnus with her fence-climbing, swearing, and medical degree; she is in turn dismayed by his conservative and anti-feminist beliefs. However, the two are united in their desire to help the poor, and by their thinly disguised physical passion for one another. But one day an argument between them goes too far; they both say things about the other's opinions and behaviours that they regret; and their developing relationship is apparently nipped in the bud. Magnus attempts to divert his passionate energies into his work and his faith, but ends up ensnared within an obsession with self-sacrifice and penance. After converting to Catholicism and entering a monastery, his decline begins in earnest, as he loses both physical and mental health. He does recover, and leaves Catholicism behind him to return to his former work amongst the poor. As he makes his rounds amongst his old acquaintances, he is shocked to discover Babs there too. She has also tried to forget about him by drowning herself in her work; and like him, the denial of love and passion, combined with an unhealthy degree of work, has ruined her health and left her blind. The two come together at the end of the story; physically and spiritually humbled, they are able to love one another with more wisdom and generosity than before.

Sweethearts and Friends **(Maxwell Grey [Mary Gleed Tutliett], 1897)** begins by placing the female protagonist, Amy Langton, as a misfit in her family. While at school in the Lake District, she became good friends with the young teacher, Louisa Stanley—Louisa, not many years older than Amy, is a heroic figure in the younger woman's eyes, with her studies in Greek, and her ambition to become a doctor. Amy begs Louisa to tutor her in Greek, and by the time Amy graduates, both are nearly ready to enter medical school. However, while Louisa is self-supporting and can decide for herself, Amy has to deal with the disapproval of her family. Her mother and sisters cannot understand why Amy is not satisfied with drawing room accomplishments, and the search for a husband; her brothers are shocked at the idea of their sister, a lady, having access to medical knowledge; and the family friend, Vivian Lester, simply cannot reconcile his Ruskin-like ideals of Womanhood with Amy's ambition, fierce good health, and prodigious appetite. In the end, Amy prevails over all objections and temptations, including Lester's offer of marriage. She joins Louisa in London to study medicine. When next we see her, five years have passed, and Amy has successfully begun medical practice. When Lester meets her in the Riviera, she is on a working holiday, taking care of Louisa, whose early toil as a teacher ruined her health, Amy's sister Grace, whose current toil as a celibate, Anglican sister has ruined *her* health, and Amy's sister-in-law, Lettice Marshall, who is recovering from a fever. Lester is pleased to see Amy again, but his stillsmouldering love is quenched somewhat by his awe of her increased strength and aura of power; he is not intimidated, however, by Lettice, who artfully sets her snare for him, and draws him in effortlessly. Amy still has feelings for Lester, and has to stand by helplessly as he becomes increasingly enamoured of what he believes is his womanly ideal incarnate—and what Amy knows is a shallow, selfish, ignorant flirt who will only break his heart. To give Lester credit, as his courtship, and then engagement , advances, he begins to see Lettice's faults; he is particularly distressed by her alternation between indifference and cruelty to his young ward, Angela; and by her flirtation with certain known rakes about town. But at this point, Lester is bound by honour to go through with the engagement; his belief in the power of a gentleman's word is so strong that he defends the Breach of Promise Act in Parliament (of which he is a member). He eventually becomes completely disgusted with Lettice's behaviour—and increasingly repentant for his previous inability to appreciate Amy's combination of beauty, moral strength, and loyalty. Fortunately for Lester, he gets his chance to escape. One night, after gently chastising Lettice for her questionable taste in reading material—and visitors (for she is still flirting with the aptly named Lovelace)—Lettice is so piqued, and overconfident, that she off-handedly releases him from his engagement. She assumes he will refuse; but Lester suavely, but decidedly, retreats from the field. Soon after, while he is still smarting from the wound, he and Amy meet again at Louisa's wedding; when they both go up to sign the register, they are horrified to discover Lettice's name already there, joined with that of the awful Lovelace. Not only has Lester been insulted, but so has Amy's other sister Georgie, who had been preparing for her wedding to Lovelace. At least Lester is now free; he begins to make cautious overtures to Amy once again. Amy has just received a prestigious appointment at the New Hospital for Woman as assistant surgeon, and is very pleased to be able to help her mother care for a house full of girls; at the same time, however, Amy is feeling very unfulfilled personally. As rewarding as her work is, she never wanted it to be her whole life; she had always hoped for the rewards of marriage also. Now she is beginning to think she will never find a man who can love her, and trust her choices for a career. For Lester has proposed again—and again, he has made it clear that he expects Amy to give up her medical work in return. She cannot accept, and they part once more. Some months later, Amy is driving through Lester's neighbourhood with her brother, when they come across a terrible house fire. A little boy is trapped in the house; suddenly, we see Lester break from the crowd and dash inside to rescue him. Lester is able to save the boy, but is too injured himself to make his own jump to safety. While the onlookers stand by in useless consternation, Amy rushes forward, and climbs up a rope to the ledge where Lester is trapped. She uses the rope to lower Lester to the waiting firemen, and jumps into the waiting net. Both are left somewhat lame (Lester) and scarred (Amy, but scarcely noticeably). But more importantly, Lester's near-death experience has led him to an epiphany. His gratitude to Amy for saving his life leads him to humility, and enlightenment—he is now able to appreciate Amy for what she is, rather than for what she is not. Lester is more than willing to trust Amy in her choice of career; she has now found the man who can offer her equitable companionship and true love.

Sydney Grier [Hilda Gregg]'s *Peace with Honour* (1897) begins by introducing us to Major Dick North, visiting his family in London after a heroic tour of duty in Africa. His sister Mabel takes him on a tour of the hospital where she volunteers. There, North is first dismayed to discover the hospital is run for women *by* women; his dismay is compounded when he discovers one of the doctors there is the one-time crush who broke his heart, Georgia Keeling. Georgia has always been attracted to North, but she finds that he is just as full of male pride and chauvinism now as he was when she rejected him years ago. After this inauspicious reunion, both are taken aback to discover that they will be working together on the same trade mission to Africa. Led by the worthy Sir Dugald Haigh, the mission's aim is to extend the colonial boundary from the existing Khemistan into the untapped but wealthy region of Ethiopia. The group will travel to the capital, Kubbet-ul-Haj, where they hope to meet with the king and his son, Rustam Khan.

The latter has persuaded his father to entertain the British envoy, after meeting them on the frontier and being impressed with their preliminary offers. But the situation will be delicate, since Rustam Khan has been in and out of favour with his father, thanks to the devious machinations of the king's Vizier, Fath-ud-Din. North has been chosen for this mission because of his proven military ability and his knowledge of local ways; Georgia, whose father was also a colonial hero in the region, hopes to further his work by gaining access to Ethiopia for medical and religious missionaries. During the journey to Africa, North becomes increasingly enamoured of Georgia, against his will; he cannot accept her professional and political beliefs. Georgia sees quite clearly that there can be no love between them if he cannot respect her for what she does, and she spends much of the trip fending off his attentions, and his arguments against the New Woman. Once the group is in Ethiopia though, romance must be put aside for duty, as danger closes in around them. As they had feared, Rustam Khan is once again out of favour, and Fath-ud-Din is determined to discredit the trade mission through any means possible. He stirs up riots against the British, tries to pass off corrupted versions of the proposed treaty, and eventually succeeds in doing serious damage by fatally poisoning the other doctor in the group, Headlam, and by using more poison to put Sir Dugald into a coma. Through the skillful intervention of Sir Dugald's attaché, Mr. Stratford, the group manages to secure a workable treaty. But the Vizier succeeds in confounding them once again, and has them taken prisoner on their way back to Khemistan, in the hopes of capturing the treaty, and replacing it with one more favourable to his interests. North is able to escape, and sets off for the British garrison in Khemistan for reinforcements—but not before he professes his love for Georgia. Georgia, who values honour and duty highly, is so impressed with North's heroism, that she is compelled to profess her love in return. Throughout these events, Georgia has managed to gain access to the king's harem, and to the confidence of the king's wife and daughter-in-law. From them she gains valuable information about the political schemes afoot; more importantly, she gains a vital clue as to the source of Sir Dugald's poisoned coma. When the party is taken captive by the Vizier's people, she learns they are very close to the stronghold of Fath-ud-Din's personal poisoner, the witch Khadija. As luck would have it, Khadija seeks Georgia out. Khadija is the caretaker of Fath-ud-Din's beloved daughter Zeynab. The girl has a serious infection in her foot, and much to Khadija's chagrin, she is unable to cure it using her own medical powers, and is forced to call in Georgia—with every intention of killing her if she gets the chance. But Georgia recognizes the opportunity to bargain with the witch for the antidote for Sir Dougald, and is willing to risk her life for the sake of the party and its leader. Georgia uses her treatment of Zeynab to pressure Khadija into confessing her secret—Zeynab's life is never in any danger, but Khadija does not know that. With the antidote safely secured, Georgia returns to the trade mission; North has also returned with the needed reinforcements and they are now free to go. The men in the party had at first been reluctant to let Georgia treat Sir Dugald; they claimed that it was only her reputation they were concerned about, not wanting her to be the object of scandal if the treatment did not work. Georgia accuses them of the more likely problem, that they do not trust her. But now that she has risked her life, and other remedies seem unlikely, they allow her to go ahead: and her extorted curative works. All that remains is for the party to return triumphantly to England, where Sir Dugald will refuse to take credit for the mission's success, conferring its honours instead on Mr. Stratford, whose diplomatic efforts saved the day. And the situation between North and Georgia must be resolved: North wants to stick to his principles, but Georgia's heroism, competence, and honour—not to mention a stern dressing-down by Lady Haigh—persuades him to finally make some diplomatic concessions of his own. He agrees to let Georgia continue her work as a medical missionary—and our last word of them reveals that they are happily married and living on the frontier, where North keeps the peace, and Georgia delivers medicine, and British culture, to the native women.

Mona Maclean, the eponymous protagonist **of *Mona Maclean, Medical Student* (Graham Travers [Margaret Todd], 1898)**, starts out in the story as a failure. Although she is widely acknowledged amongst the other female medical students to have excellent potential, she has failed her intermediate exams for the second time. Disheartened, and somewhat short on cash, on the spur of the moment she accepts an invitation from her cousin Rachel, a shopkeeper in the remote Scottish seaside town of Borrowness. Her last taste of the high life she truly loves comes some weeks before she is set to depart, when she meets some other relatives, her uncle and aunt, Lord and Lady Munro. They are at first rather doubtful about Mona's chosen calling, but she puts their fears at rest: knowledge has not made her any less the lady. What does horrify them (and all Mona's friends) is her incomprehensible decision to spend the next six months with such an inferior class of person as her mercantile cousin. To tempt Mona away from what they are sure is a terrible fate, the Munros take Mona with them to Norway; there she meets and impresses a family friend, Mr. Dickinson. He is smitten with Mona, while she regards him only as a brother. Mona is so absorbed in her academic and financial struggles that she has no thought for romance, nor has she ever had any, up to this point. After Norway, Mona, unswayed in her choice of summer retreat, goes straight to Borrowness, where she finds that Rachel is everything she had feared: crass, vulgar, snobbish to her inferiors, and obsequious to those above her. She also keeps a poor shop, and Mona soon makes the most of her position as her cousin's assistant, by restocking the shelves with fresh merchandise, and trying to persuade the local servant girls to observe a more sophisticated, yet simple, taste in bonnets. Mona does her job well, and no one suspects her true identity as a medical student, especially since Rachel has made Mona promise not to tell, for fear of scandal. Thus, when Mona meets the rough, but very likable, Dr. Dudley (visiting relatives of his own), she cannot be completely honest with him about who she is. At Christmas, Mona meets Dickinson again—he too, has connections in the area (not so remote after all). He tries to propose, but Mona is still immune to the charms of men—or at least, to the charms of this one, since her feelings for Dudley are so far undecided. She lets Dickinson down gracefully, and successfully sets him in the path of her friend Doris Colquhoun.

Doris longs to be a medical woman like Mona, but has had to give in to her father's desire that she pursue a more conventional path. Eventually, she marries Dickinson and goes with him to India, where she becomes involved in the medical care and training of local women. Meanwhile , Dudley manages to awaken Mona's latent sense of romance. He engages her help in a difficult case, caring for a young servant girl who was seduced in the big city by a so-called gentleman. She has returned to Borrowness with an illegitimate pregnancy. Mona, still not revealing her medical training, is happy to nurse the girl through her recovery—and she manages to keep the girl's mother from casting her out. Dudley drives her back from the women's remote cottage on a cold, frosty night. Mona hesitates to accept a ride from him unchaperoned, but knows that she can trust him; not only is she not insulted when he kisses her, she suddenly realizes how strongly she feels for him in return. He does not propose, though—he has let her know that he cannot think of marrying until he has finished his own medical training. Mona herself is bound to leave Borrowness immediately, to return to London and her exam preparations. She feels bound by her promise to Rachel until she leaves; and her sense of propriety dictates that since she and Dudley are not formally engaged, she cannot write to him later to explain. As far as Dudley can tell, Mona has simply disappeared, and he is bewildered by her behaviour. He does not see her again until they both go up for their exams in the summer—and when he discovers she is a medical student, he feels betrayed. He is not upset about her choice of profession—he believes that good, pure women can only be improved by the most difficult work; rather, he thinks Mona was only toying with him in Borrowness and kept her identity hidden so that she could leave him at will. So Mona has successfully passed her exams, this time with honours, but she is devastated by her separation from Dudley. Their paths cross in mutual social circles, but they do not know what to say to one another. Finally, a mutual friend, Mr. Reynolds (the father of one of Mona's friends and classmates, Lucy), is able to set Dudley straight about Mona's real business in Borrowness. Chastened, but encouraged, Dudley seeks Mona out; they apologize to one another, and become engaged. The only delay (of eighteen months) is due to the need for both of them to prepare for, and sit, their final exams. They pass, both with honours, once again, and are married. After an idyllic honeymoon, they return to London and set up practice. They decide not to pursue a fashionable clientele, choosing to help the poor instead. And, like a true *fin de siècle* couple, they practise equally, sharing their patients, with Mona specializing in the care of women and children.